U.S. Department of Labor

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Issue Date: 28 May 2004

CASE NOS.: **2003-LHC-1038**
2003-LHC-2055

OWCP NOS.: **01-156682**
01-155982

IN THE MATTER OF:

CHARLES POTTER

Claimant

v.

ELECTRIC BOAT CORPORATION

Employer

APPEARANCES:

STEPHEN EMBRY, ESQ.

For The Claimant

KEVIN GLAVIN, ESQ.

For The Employer

Before: LEE J. ROMERO, JR.
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This matter involves consolidated claims for benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901, et seq., (herein the Act), brought by Charles Potter (Claimant) against Electric Boat Corporation (Employer).[1]

[1] According to Claimant's March 27, 2003 pre-hearing statement in the matter of OWCP No. 01-155982, his claim involves "lung disease due to prolonged exposure to welding

The issues raised by the parties could not be resolved administratively and the matter was referred to the Office of Administrative Law Judges for hearing. Pursuant thereto, Notice of Hearing was issued scheduling a formal hearing on October 8, 2003, in New London, Connecticut. All parties were afforded a full opportunity to adduce testimony, offer documentary evidence and submit post-hearing briefs. Claimant offered 11 exhibits, Employer proffered 14 exhibits which were admitted into evidence along with stipulations.[2] The record was not closed subject to post-hearing development.

Claimant submitted the deposition transcripts of Dr. Milo F. Pulde and Bernard Guilotte, on October 23, 2003 and December 15, 2003, which were received as CX-12 and CX-13, respectively. On October 23, 2003, Claimant also propounded Requests for Admissions, which were received as ALJX-1a, to which Employer filed an October 27, 2003 response, which was received as ALJX-16.[3]

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fumes, paints and other irritants." The disputed issues included: (1) nature and extent of disability; (2) average weekly wage; and (3) entitlement to medical benefits under Section 7 of the Act. According to Claimant's January 18, 2003 pre-hearing statement in the matter of OWCP No. 01-156682, his claim involves an August 1, 2002 back injury. The disputed issues included: (1) nature and extent of disability; (2) average weekly wage; and (3) entitlement to medical benefits under Section 7 of the Act.

On July 2, 2003, the matters were consolidated pursuant to the Order of Administrative Law Judge Price. At the hearing, the parties agreed Claimant's claim for a back injury also included a claim for bilateral hand injuries; however, the parties also agreed Claimant has not reached maximum medical improvement from his hand injuries, which are not the subject of the instant matter. (Tr. 4-5).

[2] References to the transcript and exhibits are as follows: Transcript: Tr.___ ; Claimant's Exhibits: CX-___; Employer's Exhibits: EX-____; Claimant's Request for Admissions: ALJX-1a; Employer's Response to Claimant's Request for Admissions: ALJX-1b.

[3] Employer could not admit or deny that Claimant was exposed to injurious stimuli admittedly present at its facility. To the extent Mr. Guillotte's deposition may support specific exposure

On March 15, 2004, Counsel for Claimant submitted an Application for Attorney's Fees and Taxable Costs, seeking an attorney's fee award of $13,459.95, representing 56.95 hours of legal services at various hourly rates according to individuals working on Claimant's behalf, and total litigation costs of $2,012.45. Copies of the application for an attorney's fee were sent to all parties of record. Employer has not filed an objection to Counsel for Claimant's attorney fee petition. This decision is based upon a full consideration of the entire record.

Post-hearing briefs were received from the Claimant and the Employer on February 9, 2004, and February 2, 2004, respectively. Based upon the stipulations of Counsel, the evidence introduced, my observations of the demeanor of the witnesses, and having considered the arguments presented, I make the following Findings of Fact, Conclusions of Law and Order.

I. STIPULATIONS

At the commencement of the hearing, the parties stipulated (Tr. 5-8), and I find:

1. The Act applies in this matter.

2. Claimant has not reached maximum medical improvement from alleged hand injuries, which are not a subject of the instant matter.

3. Claimant is seeking compensation and medical benefits for a pulmonary injury, lung injury and back injury.

4. That there existed an employee-employer relationship at the time of the accidents/injuries.

5. That Claimant's average weekly wage at the time of his pulmonary injury was $936.75.

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to Claimant, the parties were urged to cite to specific page and line entries, if any, in his five (5) volume, 1248-page deposition in an Order Receiving Exhibits, Closing Hearing and Setting Brief Due Date on December 22, 2003. Pursuant to the December 22, 2003 Order, the parties were directed to file post-hearing briefs no later than January 30, 2004. The parties jointly requested an extension of the deadline to February 3, 2004, which was granted by telephone on January 29, 2004.

6. That Claimant's average weekly wage at the time of his back injury was $905.35.

7. That Claimant is not receiving compensation or medical benefits.

8. That Section 8(f) of the Act is not at issue.

II. ISSUES

The unresolved issues presented by the parties are (Tr. 6):

1. Causation; fact of back, lung and pulmonary injuries.

2. Whether Claimant's injuries occurred during the course and scope of his employment with Employer.

3. The nature and extent of Claimant's disability.

4. Entitlement to attorney's fees, interest, and annual cost of living adjustments.

III. STATEMENT OF THE CASE

The Testimonial Evidence

Claimant

Claimant was 60 years of age at the formal hearing. He has a 6th grade education. In 1969,[4] he began sandblasting as a foundry worker for Employer at its facility on the banks of the Thames river, which ships use for navigation. Claimant was exposed to dust in the foundry, which was enclosed during the winter months. In the foundry, his co-workers cut castings, made cores and melted liquid. He worked 15 months until he was laid off for one weekend. He returned to work in Employer's carpentry department for another 15 months. (Tr. 14-18).

[4] Employer's experts, Drs. Teiger and Pulde, reported that Claimant worked for Employer since 1968. (See, e.g., CX-12, p. 5; CX-12, exh. no. 1; EX-7, p. 4; EX-9, p. 4). The record otherwise includes no vocational evidence establishing when Claimant began working for Employer. For the purpose of explication, Claimant's exposure since 1969 is discussed in the analysis below.

As a carpenter, Claimant installed ceiling hardboards and fiberglass on boats. He also installed staging, insulation and tile. He periodically ripped out materials from boats as well. He regularly cut and grinded wood, which resulted in exposure to sawdust. He also sanded bondo with a grinding wheel or sand paper, which produced dust. Claimant recalled working around pipe laggers who worked with block material and installed or removed pipe insulation. Approximately once a week, the area around laggers was too dusty for Claimant to work near the laggers. He periodically cleaned areas where they worked. (Tr. 18-24).

Claimant also worked near painters, who often used needle guns to remove paint. When sandblasters would remove paint, Claimant would leave the area because it would become so dusty "You couldn't even see your hand." Claimant was laid off again for approximately six months. (Tr. 24-27).

From 1972, when Claimant returned to work with Employer, through 2002, he worked as a carpenter. He generally worked on boats near other workers, in different trades, including pipe laggers. He worked in very dusty environments near the installation and removal of pipes and pipe installation. He worked with other co-workers, "unless it got too nasty for somebody." He cut wood, which created sawdust, and ground decks, which also created dust. He often worked approximately two feet from welders. Although welding blankets were typically used to separate Claimant from welders, he would occasionally get hoarse from fumes in the area to the point he could not speak. (Tr. 27-35).

When Claimant worked near painters, he could smell epoxy paints. However, when he worked inside boats, his exposure to paint fumes was not bad due to ventilation. He often smelled solvents when he worked near painters. He would leave areas where fumes were too strong. While various trades often worked together in the same area, welders were generally separated from painters. There were times when workers in areas had to be "cleared out" because of dusty, smoky environments. Claimant occasionally worked near machinists in machine shops, but he could not remember seeing asbestos gaskets. (Tr. 35-42).

Claimant also mixed isocyanide, which involved mixing a "two-part mix" by hand. The procedure created offensive fumes and resulted in a putty which was used to fill holes. After the putty hardened, he would use a buffing machine to grind the material. He also used a variety of hand tools, including

vibrating tools. Over time, he noticed his hands would tingle. At one point, he sought medical treatment for his hands but discontinued treatment because of other medical problems. (Tr. 42-49).

In 1991 or 1992, Claimant experienced back pain after using a rope to "cleat" a submarine. A few days later, he could not walk. He underwent X-ray examination and was told that he twisted his back. His back pain, which was "mostly lower back" pain, never resolved. He continued to work with the back pain or would take a few days off if it bothered him. (Tr. 51-54).

In February 1997, Claimant underwent a physical examination as part of an isocyanide tool program. He indicated that he experienced shortness of breath. The condition has worsened since 1997. (Tr. 62-63).

In March 2002, Claimant was hospitalized for seven weeks due to pneumonia, bronchitis and emphysema. He was treated by Dr. J. P. McCormick. (Tr. 50, 60-61).

In 2002, Claimant recalled his left leg would not move while attempting to descend a ladder.[5] He "hobbled down" the ladder and reported his pain to his boss. He sought medical treatment with Dr. Gregory R. Criscuolo, who ordered an X-ray which revealed an aneurysm. He underwent surgery which "hopefully corrected" the aneurysm. (Tr. 54-58, 72-73).

Claimant experienced back pain during his tenure with Employer. His pain, which was occasionally caused by sneezing,

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[5] Claimant was not specific on the date he experienced trouble descending a ladder and the date he last worked. He indicated he last worked on May 1, 2002; however, he also stated he was injured "three months to the day" after he returned to work on May 1, 2002. Claimant expressed confusion over whether his ladder incident occurred on August 1, 2002 or May 1, 2002. (Tr. 49-50, 54). A review of Dr. Criscuolo's records indicates Claimant was "well until August 1st when he suffered a work-related injury while at Electric Boat. This developed into low back pain which progressed over the next 24 hours." Consequently, Claimant underwent a lumbar MRI which revealed an aortic aneurysm. (EX-2, p. 1). Thus, it appears Claimant worked through August 1, 2002, when he experienced climbing difficulty which ultimately led to the diagnosis of an aortic aneurysm.

generally followed periods of "all night long work." He continues to suffer from back pain. (Tr. 58).

Claimant did not return to work, and retired on December 1, 2002. He has not returned to work since retirement and receives Social Security Disability benefits.[6] He indicated that his hands were numb when he last worked and remained numb ever since. His back "always bothers" him. It periodically causes him to lie down. He uses a hydroculator when the pain increases and disables him from walking. He also takes pain medications. He is limited in his activity and does little yard and garden work. He cannot drive too far and uses a pad for sitting. (Tr. 49, 57-60, 65).

Claimant continues to suffer from shortness of breath and cannot physically exert himself because of his lungs. He added that his physical limitations are the result of the combination of his back and lung conditions. On August 1, 2002, he underwent lung surgery which revealed results that were negative for cancer. (Tr. 60-65).

Claimant recalled that he began smoking cigarettes at age 14 and last smoked on March 9, 2002. By the time he quit smoking, he was smoking one to one and a half packs of cigarettes daily. (Tr. 45-46).

On cross-examination, Claimant stated he wore a protective body suit and helmet when he sandblasted. He would not work around areas where co-workers used compressed air to remove dust. When he had a respirator, he would use it while working with isocyanide. He reiterated he gradually developed a smoking habit of one pack or more per day, but could not recall when he began smoking one pack or more daily. He quit smoking due to his hospitalization for pneumonia. (Tr. 65-69).

Claimant treated with Dr. Kenneth Korcek for his hands. He was evaluated for his lower back condition by Dr. Criscuolo at his attorney's request. He was also evaluated for his back condition by Dr. Stephen Saris at Employer's request. He was treated for his lung condition by Dr. McCormick, who relocated to Maine. After Dr. McCormick relocated, Claimant began treating for his lung condition with Dr. Leon Puppi. He was evaluated for his pulmonary condition by Dr. Michael Teiger at

[6] Claimant did not discuss receiving a pension or other retirement benefits.

Employer's request. He also treated with Dr. Bartel Crisafi, who is his "main doctor." (Tr. 65-72).

Claimant admitted his aneurysm surgery continues to cause pain; however, he no longer takes pain medications for symptoms related to the surgery. He takes pain medications for his overall back condition. Dr. Korcek prescribed a splint for his hand problem, but he has trouble sleeping with it. Claimant could not recall coldness in his hands. (Tr. 72-76).

Claimant explained that his ladder injury which precipitated the aneurysm diagnosis involved his left leg. He climbed six ladders without any problem. As he attempted to descend the ladder, his left leg did not hurt, nor did it go numb. It simply would not move. (Tr. 76-77).

The Medical Evidence

Employer's Yard Hospital

An October 1, 1970 "Chest Survey" indicates Claimant's chest examination was negative for abnormalities. The examiner's identity is not reported. (CX-8, p. 7).

A February 6, 1997 "Chest Survey" indicates Claimant was an "isocyanate worker" with abnormalities observed in his chest X-ray. Findings of COPD were noted. The examiner's identity is not reported. In a February 6, 1997 "Respiratory Medical Questionaire [sic]," Claimant reported a history of shortness of breath when climbing stairs and a history of wearing a respirator. A February 6, 1997 spirometry report reveals "moderate obstructive airways" based on an FVC level greater than 80 percent of predicted levels and a FEV1/FVC ratio less than 84 percent of predicted levels. (CX-8, pp. 1-3).

J. P. McCormick, M.D.

On March 9, 2002, Claimant was admitted to the Westerly Hospital Emergency Room in Westerly, Rhode Island, where he was treated for COPD. On March 10, 2002, he consulted at Westerly Hospital with Dr. McCormick, whose credentials are not of record, for "chronic obstructive pulmonary disease [COPD] exacerbation." He reported "wheezing for several weeks duration accompanied by increased shortness of breath," which significantly worsened prior to admission to the Westerly Hospital Emergency Room where he was treated for COPD. He also reported he was "a carpenter at [Employer] and denies

significant asbestos exposure," and described "approximately a 60-pack year tobacco history." (EX-5, pp. 1-2; CX-3, pp. 1-2).

Dr. McCormick physically examined Claimant and reviewed Claimant's laboratory data and chest X-ray,[7] which revealed hyperinflation, increased markings over the right middle lobe and a density over the right upper lobe. The density appeared nodular, but could be a scar, according to Dr. McCormick. Id.

Dr. McCormick's impressions included: (1) COPD; (2) probable right middle lobe pneumonia; (3) scarring or nodule, right upper lobe; and (4) polycythemia, perhaps indicating chronic hypoxemia. He recommended: (1) continued use of Albuterol; (2) adding Atrovent; (3) tobacco cessation; (4) checking rest and exercise oximetry on room air; (5) a chest X-ray as out-patient;[8] (6) pulmonary function tests as out-patient;[9] (7) following-up complete blood count; and (8) treatment by "Dr. Hebert," who was "covering as of 3/11/2002." (CX-3, pp. 2, 6; EX-5, pp. 2-3).

On May 14, 2003, Dr. McCormick reported to Claimant's attorney that Claimant worked as a carpenter at Employer's facility and had a "50 to 60 pack year tobacco history."

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[7] Dr. McCormick did not identify the date of X-ray examination; however, it appears he reviewed Claimant's March 9, 2002 chest films which report consistent impressions. (CX-3, pp. 7-10).

[8] On March 13, 2002, Claimant underwent a CAT scan of his chest. The CAT scan revealed "fibrous emphysema with large bullae bilaterally. There is no mass or infiltrate identified. Age related changes such as degenerative thoracic spine and atherosclerotic aorta are noted." On April 29, 2002, Claimant underwent a chest X-ray, which revealed "emphysematous changes" and no "acute disease." (CX-3, pp. 16-17).

[9] On March 25, 2002, Claimant underwent a pulmonary function test which revealed decreases in FEV1 and the FEV1/FVC ratio. The administering technician indicated Claimant had a 30-year history as a carpenter, which exposed him to "dust, chemicals [and] fumes," and a 44 pack-year history of smoking. Results identified in the report are designated as "pre-drug;" however, there is a hand-written entry indicating Claimant used a Nebulizer one hour before the test. Dr. McCormick's impression included "moderate gas transport defect and moderate obstructive ventilatory defect." (CX-3, pp. 11-12; EX-6).

Claimant "never worked directly with asbestos," but worked "around it." He had a past medical history of COPD and asthma. (CX-2, p. 1; EX-10, p. 1).

Dr. McCormick opined "the dominant process occurring here is obstructive lung disease," noting that Claimant's smoking history and his March 2002 CAT scan and September 2002 pulmonary function tests "demonstrate significant emphysema." He opined "the asbestos exposure history is somewhat nebulous." He also concluded the "major likely contributor was tobacco; however, other chronic exposures may have exacerbated his condition." Likewise, he noted Claimant's exposure to "welding fumes, wood dust and other irritants may have played a role." He concluded Claimant's pulmonary impairment is "on the order of 30 percent. I would say that tobacco contributed to 75 percent of this and other exposures to 25 percent." Id.

Walter J. Lentz, M.D.

On March 12, 2002, Dr. Lentz, whose credentials are not of record, discharged Claimant from treatment at the Westerly Hospital. In his discharge summary related to Claimant's treatment at Westerly Hospital for COPD, Dr. Lentz noted Claimant "has low back pain which he thinks is primarily due to his back. [Claimant] has avoided doctors and would rather go to a funeral parlor than a doctor." (CX-3, pp. 4-5).

Dr. Lentz reported that Claimant's condition generally rapidly improved at Westerly Hospital, except for one night in which Claimant coughed and reported chest tightness. Dr. Lentz diagnosed: (1) acute pneumonia, right lower lobe; (2) COPD; (3) a smoking habit; and (4) a possible allergy to penicillin and sinus allergies. He prescribed medications including Humibid, Levaquin, prednisone; a nicotine transdermal patch and a Combivent inhaler. He recommended Claimant undergo radiographic examination on March 13, 2002, and return for a follow-up visit one week later. He also recommended a complete blood count and a "pneumonia shot as well as a follow-up oximetry in the office to determine whether chronic oxygen is needed." (CX-3, pp. 3-5).

There is no record that Claimant returned to Dr. Lentz one week after he was discharged; however, his pulmonary function test results and X-ray results indicate he generally returned to Westerly Hospital after his discharge.

Albert J. Laurenzo, M.D.

On July 1, 2002, Claimant underwent a pulmonary function test at the request of Dr. Laurenzo, whose credentials are not of record. Claimant's 30-year history as a carpenter, which exposed him to "dust, chemicals [and] fumes," and a 44 pack-year history of smoking were noted by the administering technician. Dr. Laurenzo reported Claimant's FEV1 was "moderately decreased," while his FEV1/FVC ratio was decreased. Small airway flow rates were "significantly decreased" with significant air trapping measured by an increase in functional gas residual capacity and residual volume. Dr. Laurenzo reported, "there is no gas diffusion defect present as measured by DLCO. There is a significant reversibility with the use of [a] bronchodilator." Dr. Laurenzo's impression included "moderately severe obstructive pulmonary disease with a significant reversible bronchospastic component." (CX-3, pp. 13-15).

Gregory R. Criscuolo, M.D.

On October 22, 2002, Dr. Criscuolo examined Claimant at Counsel for Claimant's request. Claimant reported he was "well until August 1st when he suffered a work-related injury while at [Employer]. This developed into low back pain which progressed over the next 24 hours . . . [until Claimant] subsequently underwent MR imaging of the lumbar spine," which revealed degenerative disc disease and an aortic aneurysm. Claimant reported an "excellent result" from Dr. Christian's surgical treatment for his aneurysm.[10] (CX-9, p. 1; EX-2, p. 1).

Physical examination revealed "fairly good" range of motion with no sciatic notch tenderness nor any muscle spasms. Deep tendon reflexes were intact in the knees and ankles. There was no focal motor weakness. Claimant did not report numbness or tingling on physical examination. Id.

Lumbar imaging was reviewed, although the date of the lumbar image was not noted. The MRI revealed the presence of the aneurysm and some degenerative disc disease, "particularly at the L4/5 level where there is a diffuse bulge, somewhat eccentric on the right side." There was no evidence of frank

[10] Dr. Criscuolo's records include Dr. Crisafi's August 7, 2002 restriction against Claimant's return to work until further notice. There is no diagnosis on the work restriction nor indication why Claimant may not return to work. (CX-9, p. 3).

herniation nor any evidence of stenosis. Likewise, there was no indication of spondylolysis or spondylolisthesis. Id.

Dr. Criscuolo's impression included "lumbalgia related to [a] work-related injury." He noted Claimant "had an incidental abdominal aneurysm" which was successfully treated by Dr. Christian. Because Claimant was still recovering from the aneurysm surgery, Dr. Criscuolo deferred to Dr. Christian for an opinion when Claimant could begin a four to six-week physical therapy program for his lumbalgia. Dr. Criscuolo did not recommend steroid injections because Claimant did not appear to have significant sciatica. Dr. Cirscuolo planned to follow-up with Claimant in six weeks. Id. at 1-2.

On December 3, 2002, Claimant returned for a follow-up evaluation with Dr. Criscuolo, who reported Claimant was "minimally symptomatic." Claimant had some residual back discomfort with no evidence of sciatica or significant muscle spasm, and his neurologic examination was reported intact. (CX-10; EX-3).

Dr. Criscuolo opined "much of [Claimant's] significant symptoms were related to the abdominal aortic aneurysm and that clearly will take precedence with regards to any future treatments, interventions or work limitations on the near and long term. Consequently, Dr. Criscuolo deferred to Dr. Christian's recommendations against commencing physical therapy for a minimum passing of three months in which Claimant should be off work. Dr. Criscuolo planned to follow-up with Claimant three months after December 3, 2002. Id. There is no indication Claimant returned for follow-up treatment with Dr. Criscuolo three months after December 3, 2002.

Jeffery Christian, M.D.

On November 10, 2002, Dr. Jeffrey Christian, whose credentials are not of record, issued a "Disability Attending Physician's Statement" restricting Claimant, who was still recovering from aneurysm surgery, to sedentary activity. He noted Claimant, who also suffered from COPD and back problems, was treating with Drs. Crisafi and McCormick. He did not know when to expect Claimant's return to work. (CX-4).

Susan Daum, M.D.

On December 18, 2002, Dr. Daum, who is Board-certified in Internal Medicine, Preventative Medicine and Occupational

Medicine, prepared a report at the request of Counsel for Claimant, based on a review of: (1) Westerly Hospital records from March 9, 2002 through March 12, 2002; (2) Claimant's March 13, 2002 CAT scan results; (3) Claimant's March 25, 2002 pulmonary function test results; (4) Claimant's chest X-ray reports on March 29, 2002 and April 29, 2002; (5) office notes of Dr. Laurenzo;[11] and (6) "part" of a July 1, 2002 pulmonary function test report. (CX-1, p. 1).

Dr. Daum reported that Claimant was employed as a carpenter with Employer since 1969. She indicated "there was heavy exposure to asbestos from 1969 through the mid-1970's [sic], and

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[11] Very few medical records related to Dr. Laurenzo's treatment were submitted by the parties in the instant matter. (CX-3, pp. 13-15). Dr. Daum reported that Claimant treated with Dr. Laurenzo on June 26, 2002, when he reported he was a "1-2 pack/day smoker since he was 14 years old. Shortness of breath actually began about four years ago." Dr. Daum reported that Claimant returned to Dr. Laurenzo on July 10, 2002, when he complained of shortness of breath. He was "given Advair 250/50 and improved. This is the last record [Dr. Daum] had to review." Although she identified "part" of a July 1, 2002 pulmonary function test in her report, it does not appear Dr. Daum described or considered Claimant's July 1, 2002 pulmonary function test results in her report. (CX-1, pp. 1-2).

According to Dr. Pulde's August 23, 2003 medical report, Dr. Laurenzo's July 26, 2002 report "referred to Claimant's March 9, 2002 admission for 'bronchopneumonia.' A diagnosis of 'history most consistent with COPD' was made. There was no reference to an occupational lung disease including occupational asthma, 'industrial bronchitis', or asbestosis." Dr. Pulde reported that Claimant underwent pulmonary function tests on July 1, 2002, which resulted in a finding there was "no gas diffusion defect present as measured by DCLO." He further noted that Claimant was diagnosed on July 1, 2002, with "moderately severe obstructive pulmonary disease with significant reversible bronchospastic component." He reported the July 1, 2002 diagnosis included "no reference to occupational lung disease." He also noted that Dr. Laurenzo opined Claimant "had COPD as expected" on July 10, 2002. He further observed that Dr. Laurenzo diagnosed Claimant with "moderately severe COPD with significant reversibility." He reported Dr. Laurenzo's diagnosis included "no reference to occupational lung disease." Lastly, he noted Dr. Daum did not review Claimant's July 1, 2002 pulmonary function test in her report. (EX-9, pp. 4, 9-10).

continued exposure to welding fumes, grinding dust, etc. up to the present time." Claimant reported a past medical history of COPD and a "60 pack/year" smoking history. Dr. Daum noted Claimant's April 29, 2002 X-ray findings were "compatible with pulmonary and possible pleural asbestosis." (CX-1, p. 2).

Dr. Daum's review of Claimant's March 13, 2002 CT-scan revealed diffuse emphysema with multiple pleural plaques, some of which contained fibrotic changes in the surrounding lung. Some upper-lung bullae were "quite large." (CX-1, p. 3).

Dr. Daum's review of Claimant's April 29, 2002 X-ray revealed "coarse fibrotic streaks in the right lower lung zone" and other findings which were "consistent with COPD and/or emphysema. The lung fields exhibited an increase in interstitial markings with irregular linear opacities bilaterally and possible pleural thickening along the left wall. Graded by the ILO International Classification of Radiographs of Pneumoconiosis, Dr. Daum opined Claimant's "interstitial opacities are type t/s, profusion 1/0, location right lower and left middle and lower lung fields." Dr. Daum reported pulmonary and possible pleural asbestosis. (CX-1, pp. 3, 7).

Dr. Daum opined Claimant suffered from COPD and that his "occupational exposure to dust, fumes, irritants and welding fumes were significant contributing factor[s] in development of the COPD," relying on "literature in the title of several papers, 'Does Smoking Kill Workers or Does Working Kill Smokers?'" According to Dr. Daum, the literature demonstrates that "when workers are followed longitudinally, significant exposure to dust, fumes, and irritants of all types, especially dusts, is a cause of [COPD] over and above the effects of smoking." (CX-1, p. 4).

On August 29, 2003, the parties deposed Dr. Daum. She testified that she is a NIOSH Certified B-reader, who trained in the early 1970s under Dr. Irving J. Selikoff, Director of the Mount Sinai School of Medicine's Environmental Sciences Laboratory, in New York City. Dr. Selikoff actively researched asbestos treatments and the treatment of asbestos-related cancers. In the course of her work with Dr. Selikoff, Dr. Daum participated in field studies, including 1976 studies of shipyard workers at Employer's shipyard in Groton, Connecticut. The shipyard studies, which were published in 1979, included a mortality study and a study of the quantity of asbestosis found in a "large number of workers" in the shipyard. (CX-11, pp. 4-10).

In her current practice, Dr. Daum mostly treats patients suffering from occupational lung diseases, also known as "chronic non-specific lung diseases," including a variety of lung ailments that are not "specific for a single cause" such as COPD and emphysema. She also treats individuals suffering from asthma, "a separate category" of lung disease and asbestosis, which is a fibrotic disease of the lungs from asbestos inhalation. She described various tests such as spirometry used to establish symptoms of certain lung diseases including obstructive airways diseases, emphysema and asbestosis. (CX-11, pp. 10-15).

Dr. Daum described scarring related to asbestosis, which also causes obstruction to the small airways and "signs of pulmonary fibrosis, the earliest of which is decreased diffusion." Asbestosis also causes a "benign fibrotic pleurisy" which develops slowly. Evidence of the condition includes pleural thickening or calcifications of the pleura, diaphragm, or cardiac border of the mediastinum, which are the "hallmarks of asbestos exposure, especially in calcifications." She noted, "Things get muddier when you have both COPD with air trapping and emphysema and asbestosis; then it gets more confusing." (CX-11, pp. 15-19).

According to Dr. Daum, "small dust" less than 10 microns in size escape the lungs' natural mechanisms to filter dust. Such dust is related to the development of fibrosis and is "a reason that obstructive pulmonary disease occurs, whether it is from particulates in cigarette smoke or the workplace." (CX-11, p. 19).

Dr. Daum described reactive airways disease as an obstructive airways disease that may be successfully treated with medication or by refraining from exposure to irritants. The disease is "sometimes" asthma, which is an opening and closing of airways due to irritation with muscle contraction. The obstruction in asthma may be successfully treated with bronchodilators and exists "all the time." On the other hand, the obstructions generally associated with reactive airway disease are "not there all the time." (CX-11, pp. 19-21).

Dr. Daum explained people may suffer from a combination of various lung diseases, including asthma, reactive airways disease, asbestos-related interstitial disease, and COPD, including emphysema and chronic bronchitis. She concluded, "That's where things get really tricky because it is really hard

to infer exactly what is there." She added that "the patterns of observation are harder." (CX-11, p. 21).

In Claimant's case, Dr. Daum noted Claimant's pulmonary function tests revealed a "marked improvement" with the use of a bronchodilator, indicating "a very good component" of his condition is asthma, or "a more treatable form of COPD." (CX-11, p. 27). Based on the records she reviewed in her December 18, 2002 report, Dr. Daum explained Claimant's pulmonary function tests in July 2002 indicated he suffered from asthma, or asthmatic bronchitis and obstructive pulmonary disease. Based on Claimant's July 2002 medical records, which demonstrate "surprisingly low" diffusion capacity, and the March 13, 2003 CT scan, which reveals pleural thickening and large bullae at the top of both lungs, Dr. Daum opined Claimant's diffusion capacity is "from all emphysema or from a combination of emphysema and asbestosis. It is difficult to judge in this case." She noted Claimant's X-rays revealed findings consistent with "emphysema and/or COPD." (CX-11, pp. 21-27).

Counsel for Claimant described a history of Claimant's exposures to various irritants, which Dr. Daum was asked to accept as correct. Counsel discussed a history of Claimant's occupational exposures to a "significant amount of dust" since 1969 due to grinding, sandblasting, sweeping residue from sandblasting and installing fiberglass sound dampening materials. Claimant was also allegedly exposed to welding fumes, which caused Claimant to become hoarse, and to paint fumes and epoxy paints containing tolylene diisocyanate (TDI). Counsel for Claimant also described Claimant's exposure to dust from co-workers using air hoses that produced dust and fumes, which "frequently became so bad that [Claimant] would have to leave the area for his own protection." (CX-11, pp. 28-32).

Counsel for Claimant cataloged for Dr. Daum Claimant's work on submarines from 1969 through the mid-1970s, when Claimant was allegedly exposed to asbestos dust and particles, asbestos cloth, asbestos gloves, asbestos pipe lagging, asbestos welding blankets, and fire-proofing materials. Additionally, Counsel for Claimant described Claimant's history of smoking, with which Dr. Daum was familiar from a review of his medical records and her report. Id.

Dr. Daum opined that exposure to TDI, epoxies, nonspecific dusts, welding fumes and fiberglass dust are "well known" to cause asthma. She explained that grinding wheels containing tungsten carbide are known to cause COPD and interstitial

pulmonary fibrosis, while nitrogen oxides in welding fumes are the same as those found in cigarette smoke and are a known factor in the development of emphysema. Accordingly, she opined Claimant smoked and was exposed to a multiplicity of chemicals which contributed to his development of specific and non-specific obstructive pulmonary diseases, including emphysema, chronic bronchitis, asbestosis, fibrosis, asthma and COPD. Relying on an unspecified edition of the AMA Guides to the Evaluation of Permanent Impairment, Dr. Daum assigned Claimant a pulmonary impairment rating of 40-50% of the whole person. (CX-11, pp. 32-39).

Dr. Daum noted that she "ignored" asbestosis in her report because the "other disease is more prominent." She concluded Claimant probably suffered from a "component of asbestosis." (CX-11, pp. 33-34).

On cross-examination, Dr. Daum indicated she often evaluates workers for occupational diseases at the request of various companies, government agencies and individuals. In that capacity she does not provide continuing care. She has never spoken to Claimant. Her testimony is based solely upon a review of medical evidence. She does not know whether the specific pulmonary function tests which were administered to Claimant complied with American Thoracic Society protocols; however, she is familiar with Westerly Hospital and was confident the tests followed the requisite protocols. (CX-11, pp. 40-44).

Dr. Daum admitted her opinions were based upon Claimant's occupational history as related by Counsel for Claimant. She also admitted her opinions were based on the assumption that Claimant worked with grinders containing tungsten carbide, noting most grinders contain the material. (CX-11, pp. 44-45).

Dr. Daum admitted that emphysema, bronchitis and asthma may be caused equally by smoking cigarettes. The diseases may develop whether or not a shipyard worker is exposed to dust; however, they "would probably come about at a somewhat later age." In Claimant's case, "he would have had to have both a 60-pack-a-year tobacco use and an extensive occupational exposure." (CX-11, p. 45).

Dr. Daum indicated she is compensated to review medical reports and provide opinions regarding whether or not an individual has contracted an occupational disease. She was compensated for her opinions and testimony in this matter by Counsel for Claimant. A small percentage of her evaluations

result in providing testimony. She has testified in asbestos litigation most often for plaintiffs. (CX-11, pp. 45-48).

Anthony G. Alessi, M.D.

On February 24, 2003, Dr. Alessi, who is Board-certified in Neurology, evaluated Claimant, whose chief complaint was left hand numbness for a "period of years." Claimant also complained of occasional right hand numbness. Dr. Alessi noted in his review of systems that Claimant's condition was "unremarkable with the exception of back pain." Dr. Alessi did not report any back injuries, but noted Claimant recently underwent surgery for an aortic aneurysm and had a history of COPD. (CX-6, p. 1).

Based on his evaluation of Claimant, Dr. Alessis opined Claimant suffered from a mild right median mononeuropathy at the wrist. He did not find evidence of peripheral polyneuropathy or any peripheral nerve injury to the left upper extremity. He did not offer any recommendations, but anticipated results of vascular studies. (CX-6, pp. 2-4).

Vascular studies of February 24, 2003 indicated "mild to moderate digital vessel disease bilaterally [with] no evidence of abnormal vasospastic response." (CX-6, pp. 5-10).

Kenneth J. Korcek, M.D.

On April 10, 2003, Dr. Korcek examined Claimant, who reported ongoing bilateral hand pain and numbness, greater on the left side, with significant night-time symptoms. Claimant reported significant work-related symptoms after working with Employer for over 30 years with heavy use of vibratory tools. He also indicated his symptoms, especially daytime symptoms, improved somewhat. He presented results from nerve conduction studies performed by Dr. Alessi on February 24, 2003 and vascular studies performed by Vascular Associates on February 24, 2003.[12] (EX-1, p. 1; CX-7, p. 1).

[12] Previously, on April 8, 2003, Claimant visited the Thames River Orthopaedic Group, L.L.C., where Dr. Korcek works, at the request of Claimant's attorney. He visited with Dr. Korcek's physician's assistant, Peter A. Wheeler, who reported a "several-year history of numbness, tingling and loss of sensation in his hands bilaterally, left greater than right." Claimant related his hand pain to repetitive vibratory tool use while working with Employer. Claimant was unaware he should bring results of recent nerve conduction studies taken by Dr.

Physical examination revealed positive Tinel's signs at the left carpal tunnel. Tinel's signs were negative at the right carpal tunnel. Tinel's signs were negative bilaterally at Claimant's cubital tunnels. Bilateral pain and tenderness was noted with wrist extension and flexion. There was no evidence of thenar muscle atrophy. Id.

Results from Claimant's nerve conduction studies were consistent with mild right median neuropathy at the wrist. The results were otherwise normal in the upper extremities bilaterally. Results from Claimant's vascular studies revealed some evidence of peripheral vascular disease. Id.

Claimant's April 10, 2003 radiographs from Thames River Orthopedic Group indicated no evidence of fracture, dislocation or other acute bony pathology. There was evidence of "interphalangeal joint osteoarthritis, mild to moderate, most pronounced in the long and ring fingers in the right hand." Id.

Dr. Korcek's assessment included clinical left tunnel carpal syndrome and "electrodiagnostically mild right carpal tunnel syndrome with very mild bilateral epicondylitis." He recommended splinting, non-steroidal anti-inflammatory medications, corticosteroid injection and a carpal tunnel release. Claimant desired not to have surgery in favor of treating with splints and medications. If the treatments failed, Claimant would consider corticosteroid injection versus carpal tunnel release. Id. at 1-2.

Stephen Saris, M.D.

On March 1, 2003, Claimant was evaluated by Dr. Saris, whose credentials are not of record, at Employer's request. Claimant reported a history of "back problems for many years." Claimant related the problems to "an injury approximately ten years ago while working at [Employer]." He was cleating a boat, a process that requires a great deal of pulling and tugging. A

Alessi. Consequently, physician's assistant Wheeler performed no physical examination in favor of re-scheduling Claimant to visit with Dr. Korcek, who could review the test results. Mr. Wheeler's assessment included "bilateral hand pain with likelihood of carpal tunnel syndrome." Additionally, Mr. Wheeler reported Claimant was "positive for shortness of breath with exertion." Claimant reported he quit smoking "14 months ago." (CX-5).

few days after this event, he developed persistent and ongoing pain. Claimant denied having back problems prior to the described injury. (EX-4, p. 1).

Claimant reported the majority of pain was in his back, but "to a lesser degree," the pain traveled down his left leg to his ankle. His right leg felt well. The pain was mild to moderate but sometimes severe. It was "getting worse as the years go by." Dr. Saris reported, "When I asked him when his current pain began, he was very specific that it began many years ago in the 1990s. He made no mention of any accident in August 2002." (EX-4, p. 2).

Claimant also reported diminished strength and feeling in his left leg, for which he underwent physical therapy and chiropractic manipulations with no effect. He was taking pain medications and was "able to perform light domestic chores, and he is able to drive a car." Id.

Dr. Saris's review of systems indicates Claimant had "symptoms of sinus trouble, shortness of breath, poor exercise tolerance, arm weakness, leg weakness, painful joints, poor muscle strength and back pain. Physical examination was generally normal, but Dr. Saris reported diminished feeling in Claimant's feet "in a peripheral neuropathic pattern." Examination of the back itself revealed no abnormality. The painful area described was "normal to both inspection and palpation." Dr. Saris "was able to reproduce some discomfort by pressing on one spot in the right, lumbar paraspinous region." Id. at 1-2.

Claimant's August 2002 lumbosacral MRI revealed a "normal study" to Dr. Saris, who noted there were "very mild and diffuse degenerative changes." There was "slight disc darkening and settling at L1-2 and L2-3; L4-5 and L5-S1 have no degenerative changes whatsoever. There is a tiny disc protrusion in the midline at L2-3." Id. at 2.

Claimant's medical records revealed that he was treated on October 22, 2002 by Dr. Criscuolo, to whom Claimant reported an August 1, 2002 back injury. He underwent an MRI which "showed an aneurysm," for which Claimant underwent surgery. Neurological examination by Dr. Criscuolo was normal. Dr. Criscuolo diagnosed lumbalgia and recommended conservative treatment. Id.

In his assessment, Dr. Saris reported Claimant's neurological examination was normal. Dr. Saris could find "nothing wrong with him." He opined Claimant's MRI was "normal for a middle-aged man." If Claimant were his patient, Dr. Saris would recommend he should return to work "immediately without restrictions of any kind." He opined Claimant suffered from "mild and chronic degenerative arthritis of his back that is the product of advancing years and has nothing to do with either his prior occupation at [Employer], or any specific incident during his years of employment at [Employer]." Because he could find no evidence of a significant injury, Dr. Saris could not opine on causation. He opined Claimant could return to work at "normal activity at this time." Dr. Saris did not report the physical requirements of Claimant's prior work with Employer, but noted Claimant was retired. Id. at 2-3.

Michael Teiger, M.D.

On May 2, 2003, at Employer's request, Dr. Teiger evaluated Claimant. Dr. Teiger is Board-certified in Internal Medicine and Pulmonary Medicine. He is a NIOSH-certified B-reader. (EX-7, p. 1; EX-8).

In addition to his examination of Claimant, Dr. Teiger reviewed: (1) Dr. Daum's December 18, 2002 report; (2) hospital notes, consultation reports and lab work from Claimant's March 2002 admission to Westerly Hospital for right lung pneumonia; (3) Claimant's March 25, 2002 pulmonary function study; and (4) "probably all" of Claimant's chest films from March 2002. (EX-7, p. 1).

Upon evaluation, Claimant's chief complaint was "dyspnea with exertion and decreased exercise tolerance." Claimant also reported shortness of breath while walking up inclines or stairs. He indicated he could not perform yard work and "cannot bend over to weed or even tie his shoes because of difficulty catching his breath." He experienced no wheezing, but suffered from a chronic cough most of the time with occasional chest tightening. He was currently treating with Dr. Laurenzo for his pulmonary maladies and required pulmonary medication to "keep his lungs open." His symptoms increased since the occurrence of his March 2002 pneumonia. (EX-7, p. 2).

According to Dr. Teiger, Claimant was a "very heavy cigarette smoker in the past. He says that he used to smoke 1-1 1/2 packs of cigarettes a day from his early teenage years. He thinks he smoked a total of 43 years." Claimant reported that

he quit smoking in March 2002. He also described "particularly heavy exposure to asbestos dust" while working as a carpenter for Employer. The "enclosed spaces that he worked in and the typical environment on the boats in the late 1960s and 1970s were filled with asbestos dust as well as other construction and paint fumes and smoke." Claimant rarely used a respirator during the "early years in the 1970s." He later used a respirator "when he was in very dusty, contaminated places on the submarines." He reported a history of "lumbar disk surgery and carpal tunnel surgery." (EX-7, pp. 2-3).

Dr. Teiger concluded Claimant's "work history for asbestos exposure is probably significant and occurred when he worked at [Employer] from 1968 until he retired in late 2002." Dr. Teiger opined Claimant was likely exposed to "at least a moderate amount of free asbestos dust during that period," and "much, or perhaps all of his early exposure during the 1970s was largely unprotected." He was "not impressed that there were any *other* significant exposures to fumes or irritants during his work career . . . but if there were, it did not seem to cause any airways, irritations or respiratory issues." (EX-7, p. 4).

Dr. Teiger opined Claimant suffered from advanced COPD "of which emphysema is a prominent component." He concluded Claimant's March 25, 2002 pulmonary function study demonstrated a significant airway obstruction of a moderate to severe degree with a loss of diffusion capacity.[13] Claimant's disability was "significant and at the present time, his exercise tolerance could be considered to be Grade III impairment by AMA criteria. In consideration of Claimant's "heavy smoking history of 40 – 60 pack-years," Dr. Teiger opined "it is the cigarettes primarily

[13] According to Dr. Teiger, Claimant's obstruction and loss of diffusion capacity on March 25, 2002, were demonstrated by: (1) an FVC of 3.29 L (75% of predicted); (2) FEV1 of 1.61 L (51% of predicted); (3) TLC of 7.15 L (109% of predicted); (4) diffusion capacity of 55% of predicted; (5) FEV1/FVC ratio of 49% (68% of predicted); (6) RV/TLC ratio was "very elevated" at 178% of predicted; and (7) FEF25-75 was 24% of predicted. (EX-7, p. 4).

Notably, Claimant's July 1, 2002 pulmonary function tests revealed: (1) an FVC of 3.54 L (81% of predicted); (2) FEV1 of 1.81 L (58% of predicted); (3) TLC of 7.29 L (111%); (4) diffusion capacity of 54% of predicted; (5) FEV1/FVC ratio of 51% (71% of predicted); (6) RV/TLC ratio was 164% of predicted; and (7) FEF25-75 was 24% of predicted.

that are responsible for his respiratory condition." (EX-7, pp. 4-5).

According to Dr. Teiger, Dr. Daum's opinion that Claimant's occupational exposure to fumes, dust, irritants and welding fumes were significant contributing and additive factors in the development of his COPD is "certainly of theoretical validity." He noted "work-related smoke, dust and fumes are clearly respiratory irritants;" however, he opined "it is not reasonable to assume [Claimant] is as bad as he is now because he was employed in that environment." He explained that workers in similar occupations who do not smoke do not develop "anywhere near the degree of respiratory impairment that this man did." He opined Claimant "clearly could have developed the advanced state of emphysema that he has now totally exclusive of his work environment and just because he smoked." He concluded Claimant's occupational environment did not play a significant, clinically important additive role in the development of his disease. Id.

Dr. Teiger indicated the abnormalities seen in Claimant's chest X-rays were "radiographic findings for asbestosis and considering his heavy exposure to that material over the years, I would consider that he does have the condition of mild asbestosis." Claimant's disability was "entirely obstructive," and Dr. Teiger found no evidence of an "additional physiological component that could be considered to be due to the asbestosis." Id.

Dr. Teiger recommended ongoing medical treatment for Claimant's COPD, including a "routine asbestos surveillance program" supervised by an appropriate pulmonologist and an annual chest X-ray and spirometry. He recommended Claimant return to Dr. Laurenzo. Id.

Dr. Teiger would not offer an opinion on Claimant's disability related to his hand and back complaints, which were areas beyond his specialty. Based on the AMA Guide to the Evaluation of Permanent Impairment, 5th edition, Dr. Teiger assigned a "40-50% partial disability of the whole person and both lungs." He opined Claimant's disability was "caused by his smoking entirely and not by any occupational exposure," but he could not exclude the possibility that Claimant "might have a very small degree of associated asbestos present in addition." (EX-7, p. 6).

Leon D. Puppi, M.D.

On June 30, 2003, Dr. Puppi, whose credentials are not of record, referred Claimant for a surgical evaluation with Dr. Thomas Ng, whose credentials are also not of record. Dr. Puppi reported that Claimant suffered from a speculated nodule in his left upper lobe which was "highly suspicious for bronchogenic carcinoma." He noted Claimant's June 4, 2003 bronchoscopy revealed no pathology. A June 3, 2003 brain MRI revealed no evidence of metastatic disease. While a June 3, 2003 bone scan revealed evidence of uptake associated with "rib fractures due to trauma in the past," Dr. Puppi did not describe the circumstances of Claimant's prior rib injuries. Dr. Puppi reported Claimant's June 19, 2003 pulmonary function test revealed "very low focal activity in the area of the left upper lobe nodule, despite CT scan appearance that is very suspicious for malignancy." Claimant was considered an "excellent candidate for surgery, despite a 40 pack-year history of cigarette smoking." (EX-11; EX-12; EX-14).

Dr. Bartel Crisafi

On August 21, 2003, Dr. Crisafi, whose credentials are not of record, reported that Claimant was "doing a lot better." Recent test results revealed no evidence of lung cancer. Claimant was concerned he might have tuberculosis, and Dr. Crisafi recommended testing. Claimant recently had a lymph node on his left side removed. A handwritten entry on Dr. Crisafi's record indicates Claimant complained of pain in his back on September 17, 2003. (EX-13).

Milo F. Pulde, M.D.

On November 7, 2003, the parties deposed Dr. Pulde, who is Board-certified in Internal Medicine. (CX-12, p. 67).

On August 23, 2003, Dr. Pulde reviewed Claimant's medical records at Employer's request. He considered: (1) March 26, 2002 and May 28, 2002 reports from Claimant's office visits with an unidentified primary care physician; (2) Dr. Laurenzo's office notes from June 26, 2002 through July 10, 2002; (3) Dr. Teiger's May 2, 2003 report; (4) Dr. Daum's December 18, 2002 report; (5) Dr. McCormick's May 14, 2003 report; (6) pulmonary function tests dated March 25, 2002 and July 1, 2002; and (7) Westerly Hospital's admission records dated March 9, 2002. (CX-12, pp. 4-5; CX-12, exhibit no. 1; EX-9, p. 2).

Dr. Pulde opined Claimant suffered from "tobacco-related COPD with obstruction, hyper-responsiveness, and emphysema." He found no evidence that Claimant's employment at Employer's facility, which resulted in "indirect, clinically insignificant exposure to dust fumes" from 1968 to 2002, resulted in any asbestos-related pulmonary condition. Likewise, he found no evidence of occupational obstructive chronic bronchitis or occupational lung disease. He concluded that Claimant's workplace exposure from 1968 through 2002 did not contribute to any short or long-term pulmonary effect or otherwise accelerate the effects of tobacco on Claimant's lung disease.[14] (CX-12, pp. 5, 36-43, 49-55; CX-12, exh. no. 1; EX-9, pp. 7-22).

According to Dr. Pulde, the American Thoracic Society promulgated criteria for diagnosing asbestos-related lung disease: (1) substantial exposure to agents capable of producing or resulting in pulmonary disease; (2) the identification or confirmation of a disorder; and (3) the exclusion of alternative, non-asbestos-related causes of that disorder. Dr. Pulde opined Claimant did not fulfill those criteria "based on absence of substantial exposure to agents capable of resulting in pulmonary disorders, [and] the presence of [COPD] secondary to tobacco abuse, which would fully account for his pulmonary picture." (CX-12, pp. 5-6; CX-12, exh. 1; EX-9, p. 16).

Dr. Pulde noted that the opinions of Drs. Teiger, Laurenzo, McCormick and Daum support a conclusion that Claimant's tobacco consumption represented "approximately a half million cigarettes consumed over the course of his life." He opined tobacco use is the principal cause of COPD and concluded Claimant's history of tobacco use accounted for X-ray or CT-scan results on March 13, 2002, March 25, 2002, and March 29, 2002. (CX-12, pp. 6-7).

Dr. Pulde described occupational bronchitis as a "very controversial and confused disorder based on the fact that we use the term imprecisely." He noted that the disease may be classified into two categories: (1) chronic simple bronchitis, which includes cough and sputum, but no significant impairment

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[14] In his August 23, 2003 report, Dr. Pulde noted Claimant was retired. He also reported a "partial permanent rating secondary to non-work and tobacco-related COPD." Although he noted Dr. McCormick assigned Claimant a 30% impairment rating, Dr. Pulde did not assign Claimant a specific impairment rating in his report. Likewise, Dr. Pulde did not assign an impairment rating in his later reports on September 19, 2003 or October 5, 2003. (CX-12, exh. no. 1; EX-9, pp. 23-25; CX-12, exh. no. 2).

of airway function; and (2) chronic obstructive bronchitis, which involves an actual "change in the ventilatory function." Chronic obstructive bronchitis is "not proven to a reasonable degree of certainty and there is no evidence that simple exposure to dust fumes and vapors can result in fixed interfering of the airways or [COPD] as identified in [Claimant]." (CX-12, pp. 7-8).

Dr. Pulde opined Claimant's exposure to fumes, dust, gases, and asbestos fibers was "indirect and secondary." While it would be difficult to quantify Claimant's exposure, Dr. Pulde opined it would "constitute a minimal or low risk exposure for dust-associated diseases or dust-associated pulmonary diseases possibly associated with exposure to fumes and gases." Likewise, he opined Claimant's occupational exposure to welding fumes was "indirect, secondary, and, therefore, minimal." (CX-12, p. 9).

Dr. Pulde explained that the majority of the medical community accepts the view that "welders, per se, don't have an increased risk for occupational disorders, including chronic bronchitis." He noted there is "limited evidence that welding results in chronic respiratory impairment," but studies that "attempt to purport a relationship" are "flawed and use surrogate markers, such as cough, as a measure of pulmonary impairment" and are "often confounded by selection bias and certainly by underreporting of tobacco consumption." He stated the "aggregate of the literature support [sic] the absence of any affixed or airway obstruction or chronic pulmonary impairment as a consequence of direct exposure to welding fumes." (CX-12, pp. 9-10, 33-36, 38-39, 44-48).

Dr. Pulde discussed evidence that Claimant suffers from emphysema. He opined that evidence of Claimant's increased red blood count "substantiates significant tobacco consumption," which resulted in "some fixed obstruction, some reversible construction, and radiographic evidence of emphysema." He opined emphysema may be caused by smoking cigarettes, noting that cigarette smoke is comprised of "over 4,000 constituents," including carbon monoxide, tar, nicotine, nitrous oxide, hydrogen cyanide, metals and a variety of carcinogens. On the other hand, Dr. Pulde noted there is "no relationship" between emphysema and exposure to dust, vapors and fumes. (CX-12, pp. 10-13).

According to Dr. Pulde, evidence that Claimant experienced short-term relief from bronchodilators demonstrates bronchial

hyper-responsiveness consistent with "tobacco-related COPD with an asthmatic component." However, he indicated low molecular weight compounds, "such as isocyanates," may result in bronchial hyperresponsiveness. (CX-12, p. 12).

On October 5, 2003, Dr. Pulde reviewed Claimant's August 1, 2002 deposition and provided another report at Employer's request.[15] Dr. Pulde opined Claimant's testimony in addition to the other medical records he reviewed in earlier reports buttressed his opinions in his August 23, 2003 report. He opined Claimant's occupational exposure to fumes, dusts, gases and other particulates did not result in any short or long-term pulmonary disability and did not accelerate his tobacco-related COPD. He found no evidence that Claimant's occupational exposure from 1971 through 2002 resulted in any occupational lung disorder or contributed to any pulmonary limitation or compromise. (CX-12, pp. 13-16; CX-12, exh. no. 2).

Dr. Pulde explained that Claimant's indirect exposure to dusts, vapors and fumes at work are "in contradistinction to directly in-taking tobacco at the mouth, which . . . increases its effectiveness of lung penetration." He added that cigarette

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[15] On September 19, 2003, Dr. Pulde provided an "Addendum" report after reviewing additional medical evidence, including: (1) September 11, 2002 pulmonary function test results; (2) a June 3, 2003 bone scan; (3) Dr. Crisafi's June 23, 2003 and August 21, 2003 office visit reports; (4) Dr. Puppi's June 30, 2003 evaluation report; and (5) a June 4, 2003 bronchoscopy and transbronchial biopsy. (EX-9, pp. 23-24).

Dr. Pulde concluded Claimant suffered from tobacco-related COPD with findings of emphysema, relying on the September 11, 2002 pulmonary function test and the May 19, 2003 CT-scan. He opined there was no evidence of an occupational lung disorder including asbestos-related pleural plaques or parenchymal asbestosis. He found no evidence that Claimant's employment or any occupational exposure to irritants as a carpenter from 1968 through 2002 at Employer's facility contributed to Claimant's pulmonary impairment. He opined Claimant's COPD was the "direct and exclusive consequence of his high-intensity and long-duration tobacco abuse of 45- to 90-pack years." He found no evidence that Claimant's workplace exposure from 1968 through 2002 influenced the clinical course or outcome of his tobacco-related COPD. A determination on the presence of latent tuberculosis (TB) or "reactivation TB" was deferred pending a review of additional studies. (EX-9, p. 25).

smoke "gets deeper in the bronchial tubes, which accounts for the fact that it causes emphysema, which [involves] the terminal bronchial tubes. According to Dr. Pulde, "industrial bronchitis" typically "involves the larger airways, never the smaller airways, which supports the greater efficiency of distribution of tobacco." Consequently, he explained that cigarette smoke constituents "are more effectively distributed into all of the lung tissue with both mainstream and sidestream tobacco, as opposed to dust, fumes and chemicals in the air in which they are dispersed." He reiterated Claimant's exposure to dust, fumes and chemicals at work was indeterminable, but "certainly minimal and not capable of causing the pulmonary picture identified in [Claimant]." (CX-12, pp. 16-18).

Dr. Pulde also explained pleural thickening and pleural plaques are "marked for asbestos exposure." Pleural plaques may be caused by TB, lung trauma and inflammation. They affect the parietal pleura outside the lung, and "therefore, have no functional significance." In Claimant's case, he found no radiographic evidence of pleural plaques "despite Dr. Daum's opinions." Even if there were pleural plaques present, Dr. Pulde opined "they have no functional significance." (CX-12, pp. 18-19).

In "severe cases" of neural fibrosis, Dr. Pulde opined there may occasionally be a restrictive lung disorder; however, Claimant's March 25, 2002 pulmonary function test demonstrates increased lung capacity, "which supports the absence of any pleural disease resulting in any pulmonary compromise." Accordingly, Dr. Pulde opined there is no evidence of pleural plaques or pleural fibrosis in Claimant's medical records, but "even if one accepts that diagnosis, pulmonary function tests confirm the absence of any clinical significance by virtue of the fact there is no significant lung disease. (CX-12, p. 19).

On cross-examination, Dr. Pulde admitted he did not personally examine Claimant or review Claimant's X-rays, nor did he obtain an occupational history from Claimant. Rather, Dr. Pulde, who noted he was providing services in his capacity as an expert witness, reviewed Claimant's medical records and deposition testimony. Dr. Pulde has never visited Employer's facility to observe the physical requirements of carpenters. Dr. Pulde indicated Drs. Laurenzo and McCormick were Claimant's treating physicians. (CX-12, pp. 19-23).

From Claimant's testimony and medical records, Dr. Pulde understood that Claimant's carpentry job required him to erect

staging and install non-asbestos materials and fiberglass sound dampening. Claimant was also required to apply epoxy rubber. Dr. Pulde opined it is difficult to assess Claimant's actual exposures at Employer's facility based on "unfortunately a poor documented history," noting Claimant's actual exposure depends on where he worked, what processes were occurring next to him, the ambient environment, ventilation and protective measures.[16] Nevertheless, Dr. Pulde concluded Claimant would likely have been "indirectly and secondarily exposed" to dust, fumes, gases, vapors, and other particulates during the course of his employment.[17] Specifically, Claimant would have been exposed to sawdust, welding fumes, grinding dust from carbon grinding wheels and tongues, and paint fumes. (CX-12, pp. 23-26).

Dr. Pulde opined Claimant was possibly exposed to isocyanates, which could potentially cause occupational asthma, generally defined as a "reversible airway obstruction or bronchial hyper-responsiveness" and "an association between that hyper-responsiveness and exposure to agents in the workplace." According to Dr. Pulde, occupational asthma involves establishing reversible bronchial constriction and demonstrating a relationship between exposure in the workplace and bronchial hyper-responsiveness. (CX-12, pp. 26-27, 29, 63).

Dr. Pulde opined Claimant's exposure to isocyanates was not a probable basis for a diagnosis of occupational asthma because efforts to minimize exposure to isocyanates would have resulted in safe exposures to the substances without the development of bronchial hyper-responsiveness. He added that only a small percentage of individuals exposed to isocyanates develop bronchial hyper-responsiveness, and usually those individuals are indirectly exposed to high concentrations over long periods of time, "which isn't pertinent to [Claimant's] work exposure." Id.

Dr. Pulde concluded Claimant suffers from tobacco-related COPD with possible asthmatic bronchitis. Although asthmatic

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[16] Dr. Pulde referred to Claimant's deposition testimony in which Claimant allegedly stated, "I was pretty well protected, [and] used a full body suit." (CX-12, p. 25; CX-12, exh. no. 2, p. 1).

[17] In his August 23, 2003 report, Dr. Pulde noted Claimant was employed as a carpenter for Employer "with no direct exposure to dusts, oxides, or fumes from welding or any direct exposure to mineral dust." (EX-9, p. 13).

bronchitis might be considered a form of asthma, Dr. Pulde opined Claimant does not suffer from asthma because he does not have "full reversibility" with the use of a bronchodilator. Rather, he opined Claimant demonstrated a fixed, irreversible airway obstruction and abnormal dilation of terminal airways consistent with emphysema. He added that a "reversible component" caused by damage or inflammation from tobacco use leading to "some sort of twitchiness of the airways" was "superimposed upon [Claimant's] fixed airway obstruction." (CX-12, pp. 61, 64-67; EX-9, p. 18).

Dr. Pulde also concluded Claimant did not suffer from occupational asthma based on: (1) Claimant's exposure history; (2) the relationship between the exposure and symptomatology; (3) the "absence of any relationships between bad exposure and change in pulmonary function tests;" and (4) the presence of a tobacco-related chronic pulmonary disorder which would account for Claimant's clinical findings. (CX-12, pp. 61-62)

Dr. Pulde opined none of Claimant's diseases or pulmonary disorders would be a result of isocyanate exposure, which causes occupational asthma, but does not cause fixed obstructive airways disease. If he were presented evidence that Claimant installed isocyanates, he would consider the information in his opinion; however, based on the records reviewed and relevant literature, Dr. Pulde opined there is no evidence Claimant was directly exposed to isocyanates and no evidence of an isocyanate-related pulmonary disorder. (CX-12, pp. 26-28).

Dr. Pulde agreed that smoking cigarettes is a leading cause of COPD, noting that COPD is not a development in every person who smokes cigarettes. He would not agree that the development of COPD is unusual in an individual with a 40 or 45 pack-year history of smoking cigarettes, explaining that results vary according to the type of cigarettes smoked, puff volume and frequency. (CX-12, pp. 36-42).

Dr. Pulde opined exposure to asbestos may cause fibrosis beginning at small focal areas of the lung surrounding the asbestos body after inhalation. Over time, those areas may enlarge and be seen on an X-ray. Dr. Pulde generally agreed that the appearance of scarring on X-rays implies a fairly significant amount of scar tissue in the lungs because X-rays are relatively inefficient to observe small scarring in the lungs. He explained that clinically significant asbestos appearing on radiographic or CT examination and a decrease in diffusion capacity results in the "increased possibility

asbestos is the culprit." (CX-12, pp. 55-57).

Dr. Pulde opined small airways disease arises with asbestos exposure when the malady approaches end-stage, when small airways become compromised due to excessive fibrosis. He explained small airways disease is not found with simple asbestos exposure, nor is it found in individuals with a pulmonary function test that demonstrates normal tone lung capacity, normal diffusion capacity, and chest CT-scans that do not show any evidence of fibrosis. (CX-12, pp. 65-66).

Dr. Pulde opined Claimant's March 25, 2002 and July 1, 2002 pulmonary function tests demonstrated the same general findings, namely that: (1) Claimant's total lung capacity was normal, (2) lung capacities were "increased, therefore, no restrictive lung disease;" and (3) no "interstitial lung diseases contributing to asbestos." He concluded Claimant's July 1, 2002 test results revealed no diffusion defects, but opined the March 25, 2002 results demonstrated "slightly decreased" diffuse capacity, which was probably related to emphysema. He further described technical difficulty measuring diffusion capacity, which might vary according to an interpreter. He described the July 1, 2002 study as "the true study" demonstrating increased lung capacity with normal diffusion capacity consistent with chronic COPD and emphysema. According to Dr. Pulde, the July 2002 study "excludes the presence of asbestos" and is substantiated by Claimant's March 13, 2002 CT-scan that does not reveal any evidence of "lung disease secondary asbestosis." (CX-12, pp. 59-60, 64-67; EX-9, p. 18).

Other Evidence

Employer's Admissions

On October 27, 2004, Employer submitted its Response to Claimant's October 23, 2004 Request for Admissions. (ALJX-1a; ALJX-1b). Employer admitted the following:

> 1. During the period of time that Claimant was employed by Employer in Groton, Connecticut, through 1978, the pipe covering used and removed on submarines under construction and over-haul at Employer's facility contained asbestos materials.
>
> 2. During the period of time that Claimant was employed by Employer in Groton, Connecticut, from the commencement of his employment through 1978, welding

blankets used by welders in the shipyard contained asbestos materials.

3. During the period of time that Claimant was employed by Employer in Groton, Connecticut, from the commencement of his employment through 1978, the block material used by the shipyard contained asbestos.

(ALJX-1b). Employer could neither admit nor deny the following:

1. During the period of time that Claimant was employed by Employer in Groton, Connecticut, from the commencement of his employment through 1978, he was exposed to asbestos-containing cements.

2. During the course and scope of his employment with Employer, Claimant was exposed to asbestos dust and materials coming from installation and removal of asbestos-containing pipe lagging and/or welding blankets and/or block materials used by Employer during the construction and over-haul of submarines.

(ALJX-1b).

Deposition of Bernard Guillotte

Claimant submitted Mr. Guillotte's March 28, 1978 deposition transcript related to other litigation with various manufacturers, suppliers and distributors of asbestos products. Mr. Guillotte worked with Employer's insulation department, which installed and removed asbestos insulation, from 1955 through the date of his deposition, when he was general foreman supervising all pipe laggers in the department. At the time of his deposition, Mr. Guillotte suffered from asbestosis, which was diagnosed several years prior to his deposition. Mr. Guillotte recalled the majority of his work since 1955 involved nuclear submarines, including the Nautilus, Sea Wolf and Trident. Nuclear submarines required more insulation than diesel submarines. (CX-13, pp. 10-21, 88).

Mr. Guillotte was asked to describe the job requirements and working conditions of pipe laggers from 1955 through 1967. He explained that pipe laggers worked with calcium silicate and asbestos block material and asbestos pipe covering, including Kaylo and Unibestos. Laggers also worked with the following asbestos materials: pipe fittings, cement, blankets, mill board, cloth, thread, and tape. No asbestos tubing, packing or gaskets

were used by laggers. Mr. Guillotte recalled that the asbestos materials which were used in the lagging process were "dusty materials." After 1968, Mr. Guillotte recalled working with asbestos products as well as other materials, including fiberglass pipe covering. (CX-13, pp. 27-31, 42, 102-260).

Through 1967, Mr. Guillote estimated that laggers generally performed one-third of their work in a shop, although they occasionally accessed a barge. "Nearly everything" laggers worked with created dust. Some of the shop machines had individual "sucker systems," which vacuumed asbestos dust created during sawing or cutting. The shop itself had large exhaust fans on the outside wall which were used when it became warm in the building, especially during the summertime. According to Mr. Guillotte, "very, very few" other trades entered the shop where lagging occurred. Workers from the "Tin Shop" occasionally brought duct to be insulated; however, carpenters and machinists did not enter the shop because the lagging department "had no need for those people." (CX-13, pp. 31-45).

Through 1967, Mr. Guillotte estimated that laggers generally performed two-thirds of their work aboard submarines, which "always" contained exhaust systems to draw "fumes, smoke and dust." The exhaust systems, or "elephant trunks," would "vent outside the ship." While working aboard the ship, "just about every trade" worked concurrently with laggers.[18] Mr. Guillote explained that "everything we could possibly cut at the shop, the prefab, we did. Whatever had to be trimmed and fitted on a ship, we did." The additional work created "a small amount of dust." According to Mr. Guillotte, working with asbestos without creating dust "would be impossible." He noted that the paint department brush-painted pipes rather than spray painted them prior to installation when paint was required. He also noted that working with fiberglass created "very little dust." (CX-13, pp. 31, 63-79; 957; 964-965).

In addition to installations, Mr. Guillotte noted that laggers performed over-hauls, or "rip-outs." The process required the use of cast saws to cut and remove existing asbestos materials. The conditions aboard vessels while performing rip-outs were "practically the same as installation,

[18] Mr. Guillotte specifically identified painters, grinders, fitters, welders, burners, grinders, and the "entire range of machine trades," in his recollection of trades who worked concurrently with laggers aboard vessels. (CX-13, pp. 76-77).

only a little more dusty." He characterized the degree of dust during a rip-out as "the same as if you was in a wood-working shop, cutting lumber or sanding lumber . . . it's dusty." He noted it was "almost an impossibility" to avoid creating dust while performing a rip-out. Prior to 1968, Mr. Guillotte recalled just about every trade worked concurrently with laggers during rip-outs. (CX-13, pp. 80-88).

From 1968 through 1972, Mr. Guillotte recalled Employer implementing numerous improvements to the dust collection and disposal system for asbestos materials. He noted that "emergency requirements" related to asbestos were undertaken in 1971. He also recalled that OSHA requirements related to asbestos use "became part of the law" in 1972. Employer provided a "complete new barge," with various ventilation and sucker systems on every cutting bench, mixing trough and "even the grinder." Employer began regularly monitoring the air aboard the barge for dust. (CX-13, pp. 45-46; 258-259; 536; 652-661).

Likewise, "quite a number of changes" were made in the shop, which was "completely upgraded" with a new ventilation system and exhaust systems, which were installed on every cutting table, working bench, band saw and mixing trough. Every lagger working with any asbestos material was required to wear respirators. Employer began monitoring the air in the shop for dust. (CX-13, pp. 45-46; 258-259; 536; 652-661; 887; 1056-1057; 1190).

Mr. Guillotte explained Employer likewise implemented changes aboard the submarines in 1969 or 1970. Efforts were made to keep other trades, or "bystanders," from submarines during rip-outs. Jobs requiring the removal of asbestos insulation were changed to "off-shift" periods and weekends to allow "very few people as possible in the compartment when we're doing rip-outs." Areas where insulation removal occurred were only open for the insulation department. (CX-13, pp. 259-266, 491; 698-670; 819-820; 835; 974; 1021; 1056-1057).

In 1969, Employer began monitoring dust counts during rip-outs and required laggers to use air-fed respirators, which were available in every area of a ship, and to continuously run vacuum cleaners during all rip-outs. Prior to 1969, respirators were not air-fed, nor were they required aboard the submarines, where most workers chose not to use them because asbestos dust was considered a mere nuisance. Employer also required its laggers to wear coveralls, boots, hats and gloves while working

with asbestos. Id.

Mr. Guillotte recalled that Employer "started to eliminate all the asbestos products and tried to get replacement materials as early as 1970." He recalled that the use of asbestos blankets and tape was discontinued in 1970 or 1971. By 1971, Mr. Guillotte estimated all workers in the insulation department knew of the alleged hazards of asbestos. By 1974, the use of all asbestos materials was discontinued, except for only one product, a government-provided portable insulation product. (CX-13, pp. 134-135, 259-261; 844; 1063; 1190).

Mr. Guillotte estimated the levels of dust aboard submarines in 1978 were roughly equivalent to those prior to the implementation of the ventilation and exhaust changes, "but we don't have the asbestos in the insulation." However, most of the dust in the shop and on barges was eliminated. (CX-13, pp. 849-850).

Mr. Guillotte indicated he smoked cigarettes since he was fifteen years old and continued smoking at the time of his deposition. He recalled "quite a few" co-workers smoking during the construction of vessels, installation of insulation or during rip-outs. Workers were not allowed to smoke while painters were painting. (CX-13, pp. 1039-1041).

The Contentions of the Parties

Claimant contends he sustained pulmonary injuries, namely COPD, asthma and emphysema, from his occupational exposure to asbestos, welding fumes, grinding dust, paint fumes, isocyanate fumes and wood dust over the course of his employment with Employer since 1968. Based on the opinion of Dr. McCormick, his attending pulmonologist, Claimant argues 25% of his pulmonary condition is work—related. He claims he suffers from asbestosis and fibrosis of the lungs, which are also the results of his occupational exposures to irritants over the course of his employment with Employer since 1969.

Claimant also contends that he suffers from carpal tunnel syndrome and other hand injuries related to vibration and repetitive trauma to his wrists, despite his concession at the formal hearing that his hand claims are not the subject of the instant inquiry. He argues that he suffers from back pain related to a work injury in the 1990s and a recurrence of back pain while climbing ladders in March 2002. Claimant does not contend his aortic aneurysm is work-related. He concedes his back condition "would not be so severe as to drive him from work

alone, [but] it must be considered in conjunction with his pulmonary and hand problems." In consideration of his various maladies, Claimant avers his work-related disability status is permanent total. He seeks compensation benefits and medical benefits for his occupational disabilities.

Employer contends Claimant's hand injuries are premature insofar as Claimant admitted his hand condition has not yet reached maximum medical improvement, which is consistent with Dr. Korcek's medical reports. Moreover, Employer contends Claimant has not been assigned an impairment rating, which precludes an award at this time. Employer disputes that Claimant's back injury was caused by his employment. Rather, it contends Claimant's back complaints are related to a non-occupational aortic aneurysm. Lastly, Employer argues that Claimant's lung and pulmonary conditions are the results of non-occupational tobacco use.

IV. DISCUSSION

It has been consistently held that the Act must be construed liberally in favor of the Claimant. Voris v. Eikel, 346 U.S. 328, 333 (1953); J. B. Vozzolo, Inc. v. Britton, 377 F.2d 144 (D.C. Cir. 1967). However, the United States Supreme Court has determined that the "true-doubt" rule, which resolves factual doubt in favor of the Claimant when the evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act, 5 U.S.C. Section 556(d), which specifies that the proponent of a rule or position has the burden of proof and, thus, the burden of persuasion. Director, OWCP v. Greenwich Collieries, 512 U.S. 267, 114 S.Ct. 2251 (1994), aff'g. 990 F.2d 730 (3rd Cir. 1993).

In arriving at a decision in this matter, it is well-settled that the finder of fact is entitled to determine the credibility of witnesses, to weigh the evidence and draw his own inferences therefrom, and is not bound to accept the opinion or theory of any particular medical examiners. Duhagon v. Metropolitan Stevedore Company, 31 BRBS 98, 101 (1997); Avondale Shipyards, Inc. v. Kennel, 914 F.2d 88, 91 (5th Cir. 1988); Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce, 551 F.2d 898, 900 (5th Cir. 1981); Bank v. Chicago Grain Trimmers Association, Inc., 390 U.S. 459, 467, reh'g denied, 391 U.S. 929 (1968).

A. Claimant's Alleged Hand Injuries

As noted above, the parties agreed at the hearing that Claimant's hand injuries, which are scheduled injuries under the Act, were not the subject of this matter. Nevertheless, Claimant argues in his brief that he sustained work-related hand injuries, including carpal tunnel syndrome, over the course of his employment with Employer.

As a general rule, if an injury occurs to a body part specified in the statutory schedule, then the injured employee is limited to the permanent partial disability schedule of payment contained in Sections 908(c)(1) through (20). The rule that the scheduled benefits are exclusive in cases where the scheduled injury, limited in effect to the injured part of the body, results in a permanent partial disability was thoroughly discussed by the Supreme Court in Potomac Electric Power Company v. Director, OWCP [PEPCO], 449 U.S. 268, 101 S. Ct. 509, 66 L. Ed. 2d 446 (1980). However, a scheduled injury can give rise to permanent total disability pursuant to Section 908(a) in an instance where the facts show that the injury prevents a claimant from engaging in the only employment for which he is qualified. PEPCO, 101 S. Ct. at 514 n. 17. Therefore, if Claimant establishes that he is totally disabled, the schedule becomes irrelevant. Dugger v. Jacksonville Shipyards, 8 BRBS 552 (1978), aff'd, 587 F.2d 197 (5th Cir. 1979).

Assuming **arguendo** that he could establish compensable hand injuries, Claimant testified he is unable to return to work due to a combination of his back and lung conditions. He has not argued his hand injuries preclude his return to work. On the other hand, he described years of capably performing his work without excessive pain or great hardship, despite his alleged hand injuries. Further, there is insufficient indication in his medical records that he is precluded from returning to work because of his alleged hand injuries. Consequently, because Claimant has not established he is totally disabled from returning to his prior occupation due to his alleged hand injuries, his disability status due to his hand disability is partial, and the schedule under the Act is applicable.

Accordingly, for the reasons asserted by the parties at the formal hearing and reiterated in Employer's brief, namely that Claimant has received no permanent impairment ratings as a result of his alleged hand injuries and that Claimant has not yet reached maximum medical improvement from his hand injuries, I reject Claimant's invitation to consider his alleged hand

injuries herein and remand the matter to the District Director for further consideration.

B. The Compensable Injury

Section 2(2) of the Act defines "injury" as "accidental injury or death arising out of or in the course of employment." 33 U.S.C. § 902(2). Section 20(a) of the Act provides a presumption that aids the Claimant in establishing that a harm constitutes a compensable injury under the Act. Section 20(a) of the Act provides in pertinent part:

> In any proceeding for the enforcement of a claim for compensation under this Act it shall be presumed, in the absence of substantial evidence to the contrary-that the claim comes within the provisions of this Act.

33 U.S.C. § 920(a).

The Benefits Review Board (herein the Board) has explained that a claimant need not affirmatively establish a causal connection between his work and the harm he has suffered, but rather need only show that: (1) he sustained physical harm or pain, and (2) an accident occurred in the course of employment, or conditions existed at work, which **could have caused** the harm or pain. Kelaita v. Triple A Machine Shop, 13 BRBS 326 (1981), aff'd sub nom. Kelaita v. Director, OWCP, 799 F.2d 1308 (9th Cir. 1986); Merrill v. Todd Pacific Shipyards Corp., 25 BRBS 140 (1991); Stevens v. Tacoma Boat Building Co., 23 BRBS 191 (1990). These two elements establish a **prima facie** case of a compensable "injury" supporting a claim for compensation. Id.

1. Claimant's Pulmonary and Lung Conditions

a. Claimant's Prima Facie Case

Claimant's **credible** subjective complaints of symptoms and pain can be sufficient to establish the element of physical harm necessary for a **prima facie** case and the invocation of the Section 20(a) presumption. See Sylvester v. Bethlehem Steel Corp., 14 BRBS 234, 236 (1981), aff'd sub nom. Sylvester v. Director, OWCP, 681 F.2d 359, 14 BRBS 984 (CRT)(5th Cir. 1982).

In the present matter, the parties dispute the existence and causation of certain pulmonary and lung conditions; however,

they agree that Claimant suffers from at least COPD. Meanwhile, Employer could neither admit nor deny that Claimant was exposed to asbestos at its facility during the course of his employment through 1978; however, Employer admitted that lagging materials, welding blankets and block material used at its facility through 1978 contained asbestos. The parties do not dispute that Claimant worked with isocyanates.

Claimant contends occupational exposures to various irritants and harmful stimuli over the course of his employment with Employer since 1969 contributed to his development of COPD and other lung and pulmonary conditions, generally relying on Dr. Daum's opinion that his exposures were significant contributing and additive factors in the development of his conditions. According to Employer's expert, Dr. Teiger, Dr. Daum's opinion is "certainly of theoretical validity" as occupational smoke, fumes and dust are respiratory irritants.

Thus, I find Claimant has established a **prima facie** case that he suffered an "injury" under the Act, having established that he suffered a harm or pain over the course of his employment, and that his working conditions and activities during his employment could have caused the harm or pain to invoke the Section 20(a) presumption. Cairns v. Matson Terminals, Inc., 21 BRBS 252 (1988).

b. Employer's Rebuttal Evidence

Once Claimant's **prima facie** case is established, a presumption is invoked under Section 20(a) of the Act that supplies the causal nexus between the physical harm or pain and the working conditions which could have cause them.

The burden shifts to the employer to rebut the presumption with substantial evidence to the contrary that Claimant's condition was neither caused by his working conditions nor aggravated, accelerated or rendered symptomatic by such conditions. See Conoco, Inc. v. Director, OWCP [Prewitt], 194 F.3d 684, 33 BRBS 187 (CRT)(5th Cir. 1999); Gooden v. Director, OWCP, 135 F.3d 1066, 32 BRBS 59 (CRT)(5th Cir. 1998); Louisiana Ins. Guar. Ass'n v. Bunol, 211 F.3d 294, 34 BRBS 29(CRT)(5th Cir. 1999); Lennon v. Waterfront Transport, 20 F.3d 658, 28 BRBS 22 (CRT)(5th Cir. 1994). "Substantial evidence" means evidence that reasonable minds might accept as adequate to support a conclusion. Avondale Industries v. Pulliam, 137 F.3d 326, 328 (5th Cir. 1998); Ortco Contractors, Inc. v. Charpentier, 332 F.3d 283 (5th Cir. 2003) (the evidentiary standard necessary to

rebut the presumption under Section 20(a) of the Act is "less demanding than the ordinary civil requirement that a party prove a fact by a preponderance of evidence").

Employer must produce facts, not speculation, to overcome the presumption of compensability. Reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created by Section 20(a). See Smith v. Sealand Terminal, 14 BRBS 844 (1982). The testimony of a physician that no relationship exists between an injury and a claimant's employment is sufficient to rebut the presumption. See Kier v. Bethlehem Steel Corp., 16 BRBS 128 (1984).

If an administrative law judge finds that the Section 20(a) presumption is rebutted, he must weigh all of the evidence and resolve the causation issue based on the record as a whole. Universal Maritime Corp. v. Moore, 126 F.3d 256, 31 BRBS 119(CRT)(4th Cir. 1997); Hughes v. Bethlehem Steel Corp., 17 BRBS 153 (1985); Director, OWCP v. Greenwich Collieries, supra.

Employer submitted the medical opinions of Dr. Pulde, who concluded Claimant's lung and pulmonary conditions are entirely caused by his history of smoking cigarettes rather than occupational exposures to irritants while working for Employer. Consequently, I find Employer has sufficiently rebutted the Section 20(a) presumption, and the record must be weighed as whole.

c. Weighing the Entire Record Evidence

Prefatorily, it is noted the opinion of a treating physician may be entitled to greater weight than the opinion of a non-treating physician under certain circumstances. Black & Decker Disability Plan v. Nord, 123 S.Ct. 1965, 1970 n. 3 (2003) (in matters under the Act, courts have approved adherence to a rule similar to the Social Security treating physician rule in which the opinions of treating physicians are accorded special deference) (citing Pietrunti v. Director, OWCP, 119 F.3d 1035 (2d Cir. 1997) (an administrative law judge is bound by the expert opinion of a treating physician as to the existence of a disability "unless contradicted by substantial evidence to the contrary")); Rivera v. Harris, 623 F.2d 212, 216 (2d Cir. 1980) ("opinions of treating physicians are entitled to considerable weight"); Loza v. Apfel, 219 F.3d 378 (5th Cir. 2000)(in a Social Security matter, the opinions of a treating physician were entitled to greater weight than the opinions of non-treating physicians).

Claimant argues the opinions of Dr. McCormick should be entitled to greater weight because Dr. McCormick was Claimant's "attending physician." However, the record, which is principally composed of evaluating experts' reports and opinions, does not establish Dr. McCormick, whose credentials are not of record, is uniquely familiar with Claimant's condition or is otherwise situated to render medical opinions of greater probative value based on his treatment of Claimant during a very brief period in March 2002. Accordingly, I find Dr. McCormick's opinions do not compel special deference as the opinions of a treating physician, and shall be accorded their proper probative value.

Additionally, it is noted that Mr. Guillotte's deposition, which was submitted to establish Claimant's working conditions by inference, relates primarily to the job conditions of pipe laggers rather than carpenters. According to Mr. Guillotte's testimony, laggers were a unique trade which occasionally worked concurrently with other trades aboard ships. Moreover, his testimony regarding asbestos exposure generally relates to years prior to 1968, before Claimant began working with Employer.

Although Mr. Guillotte's testimony arguably indicates Employer began taking proactive measures to avoid asbestos exposure by its workers around the time Claimant began working at its facility, I am inclined to agree with Employer that Mr. Guillote's testimony does not establish Claimant's exposures to harmful stimuli because Mr. Guillotte did not refer to Claimant in his deposition, nor did he describe the job requirements of carpenters. Although Mr. Guillotte testified all asbestos materials were discontinued at Employer's facility by 1974, Employer admitted using the materials through 1978. Further, the record does not establish Claimant provided services at the specific worksites which Mr. Guillotte described.

Of the record medical opinions relating to Claimant's pulmonary and lung conditions, the most thorough opinions were offered by Drs. Daum and Pulde, who reviewed medical records and evidence, were deposed and subjected to cross-examination. To the extent they are supported by the record, I find them more persuasive than the opinions and scant medical records of Drs. Lentz, Laurenzo and McCormick, whose credentials are not of record and who treated Claimant briefly in March 2002.[19]

[19] Employer asserts that it is "odd" that Claimant did not submit any records from Dr. Laurenzo, Claimant's treating

Likewise, I find the opinions of Drs. Daum and Pulde of greater probative value than those of Dr. Teiger, who, like Dr. McCormick, prepared a report, but was neither deposed nor subject to cross-examination.

Dr. Daum's opinion that Claimant smoked and was exposed to harmful stimuli which contributed to his development of specific and non-specific obstructive pulmonary diseases, including emphysema, chronic bronchitis, asbestosis, fibrosis, asthma and COPD is diametrically opposed by Dr. Pulde's opinion that Claimant's condition is entirely caused by his history of smoking cigarettes rather than his occupational exposure to harmful stimuli.

Employer argues Dr. Daum's opinion should be discredited because she never met Claimant nor took his history, but instead relied on "gross assumptions as to his work environment exposures." Similarly, Claimant observes that Dr. Pulde did not perform a physical examination of Claimant, whose limited records formed the basis of Dr. Pulde's assumptions regarding Claimant's occupational exposures. Both medical experts demonstrated impressive familiarity with lung and pulmonary disorders and offered insightful explanations which are helpful for a resolution of the instant matter. Accordingly, I am disinclined to entirely discredit either physician for failing to personally examine Claimant or for relying on certain occupational assumptions, which may be weighed against the entire record and which are arguably necessary to render complete diagnoses.

(1) Asbestosis and Fibrosis

I find Dr. Daum's opinion that Claimant suffered from asbestosis and fibrosis are more persuasive than Dr. Pulde's opinions that Claimant does not suffer from asbestosis and that Claimant's radiological results revealed no evidence of fibrosis. Employer's other expert, Dr. Teiger, who, like Dr. Daum, is a certified B-reader, agreed with Dr. Daum's diagnosis of asbestosis based on a review of Claimant's radiological results. While Dr. Daum reviewed Claimant's April 29, 2002 X-

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pulmonologist since June 26, 2002. It is noted that there is no evidence or allegation that Employer sought to discover Dr. Laurenzo's records or was otherwise prohibited by Claimant from obtaining the evidence. It is also noted that Dr. Laurenzo's July 1, 2002 pulmonary function report is of record. (CX-3, pp. 13-15).

ray, which she opined demonstrated coarse fibrotic streaks, Dr. Pulde admitted he reviewed no X-rays, which detracts from his medical opinions regarding Claimant's radiological results. Moreover, a review of Claimant's radiology reports reveals evidence of scarring, fibrous emphysema, interstitial markings and densities, which reportedly "could be fibrotic." Accordingly, I find Dr. Daum's opinion that Claimant suffers from asbestosis and fibrosis is supported by the record and by Dr. Teiger's opinion in establishing Claimant suffers from those conditions as a result of his occupational exposure to irritants over the course of his employment for Employer.

Among Drs. Daum, Teiger and Pulde, Dr. Pulde, stands alone in his opinion that Claimant's employment at Employer's facility resulted in "indirect, clinically insignificant exposure to dust fumes" which did not result in any asbestos-related pulmonary condition. I find Dr. Pulde's admission that he never visited Employer's facility to observe the physical requirements of carpentry jobs denigrates his overall estimations of Claimant's occupational exposure as a carpenter at Employer's facility since 1969. Rather, I am favorably impressed with the testimony of Claimant, who credibly described exposure to harmful stimuli, including asbestos, isocyanates, wood dust, welding fumes, fiberglass dust, grinding dust and fumes while performing carpentry work in dusty environments aboard vessels near other trades, including pipe laggers, welders, cleaners, sandblasters and painters, and elsewhere within Employer's facility since 1969.

Employer's admissions that pipe insulation, block material and welding blankets used through 1978 contained asbestos arguably supports Claimant's contention, which Employer could not deny, that he was exposed to asbestos through 1978 while performing his job while working or cleaning areas near welders and pipe laggers. I find Claimant, who was employed by Employer at its facility since 1969, is in the best position of record to estimate his exposure to dust since 1969.

Relying on Dr. McCormick's March 10, 2002 notation that Claimant denied "significant" asbestos exposure, Employer contends Dr. Daum's medical opinions in her December 18, 2002 report should be dismissed because Claimant's exposure to dusts and welding fumes were not established in the limited medical records Dr. Daum reviewed. Notably, Dr. McCormick later reported that Claimant "never worked directly with asbestos," but worked "around it." The parties did not depose Dr. McCormick or obtain his explanation for his entry that Claimant

denied "significant" asbestos exposure.

On the other hand, Dr. Daum was deposed, and I find her description of participating in field studies of mortality rates and asbestos exposure in a "large number of workers" at Employer's facility during the 1970s is not inconsistent with Claimant's position that he was exposed to asbestos at Employer's facility during the 1970s. Likewise, I find Dr. Daum's reliance on an occupational description provided by Claimant's counsel enhances her persuasiveness because the occupational description is not inconsistent with Claimant's testimony that he was exposed to irritants, including asbestos, over the course of his employment with Employer since 1969.

Meanwhile, Dr. Daum clearly relied on other objective evidence established by X-ray examination to conclude that Claimant suffered from fibrosis and asbestosis. As noted above, Dr. Teiger agreed with Dr. Daum based on his review of the same X-ray. Consequently, I find Employer's argument that Dr. Daum's medical opinions in her December 18, 2002 report should be dismissed because Claimant's exposure to dusts and welding fumes were not established in the limited medical records reviewed by Dr. Daum is not persuasive.

It is noted that the congruent opinions of Drs. Daum and Teiger are arguably consistent with Dr. Pulde's opinion that clinically significant asbestos appearing on radiographic examination in conjunction with a decrease in diffusion capacity suggests asbestos is a "culprit" insofar as Drs. Daum and Teiger observed clinically significant asbestos in Claimant's April 29, 2002 X-ray and found evidence of decreased diffusion capacity in Claimant's March 25, 2002 pulmonary function test results. Dr. Pulde conceded Claimant's March 25, 2002 results were "slightly decreased." I find his explanation that some variation occurred between March 25, 2002 and July 1, 2002, as a result of "twitchiness" in Claimant's airways is not persuasive.

Dr. Pulde diverged from the opinions of Drs. Daum and Teiger based on his own opinion that Claimant's July 1, 2002 pulmonary function test results demonstrated no diffusion defects. His opinion, which is arguably based on Dr. Laurenzo's July 1, 2002 entry that "there is no gas defect present as measured by DCLO" is contrary to Dr. Daum's opinion that Claimant's July 1, 2002 results reveal "surprisingly low" diffusion capacity.

As noted above, I find little persuasiveness in the sparse medical records of Dr. Laurenzo, whose credentials are not of record. Moreover, Dr. Pulde's opinion that Claimant demonstrated "no" diffusion defects on July 1, 2002, when his diffusion was "54%" of predicted, is belied by Dr. Pulde's opinion that Claimant demonstrated "slightly decreased" diffusion capacity on March 25, 2002, when Claimant's diffusion was "55%" of predicted.

Rather, I am inclined to conclude that Claimant demonstrated decreased diffusion capacity in his July 1, 2002 pulmonary function test results based on the more reasoned medical opinion of Dr. Daum. It is noted that Claimant's July 1, 2002 results are very similar to the results obtained on March 25, 2002. The criteria used by Employer's expert, Dr. Teiger, to establish decreased diffusion capacities on March 25, 2002, were little changed, if at all, on July 1, 2002.

In light of the foregoing, I find Claimant established that he suffers from asbestosis and fibrosis as a result of his occupational exposure to irritants over the course and scope of his employment with Employer since 1969.

(2) COPD and Emphysema

I find Dr. Daum's opinion that Claimant's occupational exposures to harmful stimuli contributed to his COPD and emphysema are more persuasive and well-reasoned than Dr. Pulde's opinion that Claimant's condition is entirely the result of smoking cigarettes. Dr. Daum's opinion that Claimant's conditions are the result of tobacco use and "an extensive occupational exposure" is consistent with Claimant's descriptions of smoking cigarettes and being exposed to harmful stimuli over the course of his employment with Employer.

Dr. Daum's opinion that Claimant's occupational exposure contributed to the development of his condition, including COPD, is supported by Dr. Teiger's opinions that her opinion is "certainly of theoretical validity" and that occupational dust, smoke and fumes are "clearly respiratory irritants." I find Dr. Teiger's "remark" that "most workers in similar occupations who do not smoke do not develop anywhere near the degree of respiratory impairment this man did" indicates by inference that those workers in similar occupations who do not smoke develop at least some degree of respiratory impairments.

Moreover, I find Dr. Teiger's opinion that "it is the cigarettes **primarily** that are responsible" for Claimant's respiratory condition is not inconsistent with Dr. Daum's opinion that Claimant's tobacco use and occupational exposures contributed to the development of his condition. Further, I find Dr. Teiger's opinion vacillates elsewhere in his report by concluding Claimant's condition was "caused by his smoking **entirely** and not by any occupational exposure but cannot exclude that he might have a very small degree of associated asbestos present in addition." Accordingly, I am not persuaded by Dr. Teiger's opinion to conclude Claimant suffers from a condition wholly unrelated to his employment with Employer since 1969.

Likewise, Dr. Daum's opinion that Claimant's occupational exposure contributed to the development of his condition, including COPD, is supported by Dr. McCormick's May 14, 2003 report that Claimant's pulmonary condition is related in part to his occupational exposure with Employer. Employer argues that Dr. McCormick's report should be dismissed because it was prepared well after his treatment of Claimant for pneumonia and because the report "would appear" that the "sole purpose" of Dr. McCormick's report was to "put a work-related cause to [Claimant's] previously diagnosed COPD."

I find Dr. McCormick's conclusions do not appear attenuated by the passage of time in consideration of Dr. Daum's well-reasoned opinion that Claimant's occupational exposures contributed to his conditions and in view of Dr. Teiger's opinion that such a conclusion "certainly has theoretical validity." Regardless of any alleged "purpose" for Dr. McCormick's report, I find no compelling reason to completely ignore the medical opinions reported by Dr. McCormick on May 14, 2003.

As noted above, I find Dr. Pulde's opinions that Claimant's occupational exposure to fumes, dust and asbestos fibers was "indirect and secondary," constituting a "minimal or low-risk exposure for dust-associated diseases or pulmonary diseases" are not persuasive, nor consistent with Claimant's uncontroverted testimony. Likewise, I find Dr. Teiger's opinion that Claimant was not exposed to any "significant" exposures to fumes or irritants during his work for Employer after the 1970s is not established in the record. Dr. Teiger's notations that Claimant was exposed to "usual fumes and dusts that would be associated" with carpentry and that Claimant "reported no unusual chemicals" does not adequately explain the extent to which Claimant was exposed to the harmful stimuli identified in this matter.

In light of the foregoing, I find Claimant established that his occupational exposures to harmful stimuli over the course of his employment with Employer since 1969 contributed to the development of his pulmonary and lung conditions, including COPD and emphysema.

(3) Asthma

It is undisputed that Claimant worked with isocyanates at Employer's facility, as noted in Claimant's Chest Survey on February 6, 1997, when he reported shortness of breath while climbing stairs and when findings of COPD were noted. Based on the medical opinion of Dr. Daum, who reasonably explained that the harmful stimuli, including isocyanates, epoxies, non-specific dusts, welding fumes and fiberglass are "well-known to cause asthma," I am inclined to conclude Claimant established his asthmatic condition is related to his occupational exposures to the stimuli during the course of his employment with Employer since 1969.

Dr. Daum's opinion, that Claimant suffers from asthma as a result of his occupational exposures to harmful stimuli, is not challenged by Dr. Teiger, who only noted that Claimant "reported no unusual chemicals" and that Claimant was exposed to the "usual fumes and dusts that would be associated" with carpentry. Dr. Teiger, who did not discuss Claimant's asthma, was apparently unaware of Claimant's exposure to isocyanates and otherwise failed to discuss the effects of exposure to isocyanates, epoxies, non-specific dusts, welding fumes and fiberglass in the development of asthma.

Likewise, Dr. Pulde was unaware Claimant worked with isocyanates while working for Employer. According to Dr. Pulde, who clearly reported that exposure to isocyanates at the workplace may lead to the development of bronchial hyper-responsiveness or occupational asthma, there is no evidence Claimant was directly exposed to isocyanates nor suffers from an isocyanate-related pulmonary disorder. His opinion is inconsistent with Claimant's testimony regarding his job description as an isocyanate worker, and arguably overlooks Dr. Laurenzo's July 1, 2002 report of Claimant's "significant reversible bronchospastic component," Dr. McCormick's May 14, 2003 report that Claimant's improvement with the use of a bronchodilator was "consistent with a diagnosis of asthma," and Dr. Daum's August 29, 2003 opinion that Claimant's pulmonary function tests revealed a "marked improvement" with the use of a

bronchodilator, indicating a "very good component" of Claimant's condition is asthma.

Lastly, I find Dr. Pulde's opinion that Claimant does not suffer from asthma because he does not have "full reversibility" with the use of a bronchodilator vacillates from his testimony elsewhere that Claimant possibly suffers from asthmatic bronchitis, which he opined may be considered a form of asthma. Further, in consideration of medical evidence, reports and opinions supporting a diagnosis of asthma and bronchial hyper-responsiveness, I am not persuaded by Dr. Pulde's unsupported explanation that Claimant's "reversible component" of his airway obstruction is merely the result of tobacco-related "twitchiness of the airways" that is "superimposed on a fixed airway obstruction."

Accordingly, based on Dr. Daum's persuasive, well-reasoned and factually supported medical opinion, I find Claimant's occupational exposures to harmful stimuli over the course of his employment with Employer since 1969 contributed to the development of bronchial hyper-responsiveness or asthma.

2. Claimant's Back Injury

Claimant described suffering ongoing back pain resulting from his 1991 or 1992 cleating incident. Notably, if the 1991 or 1992 cleating incident solely caused Claimant's back symptoms, there is no record evidence of any contemporaneous medical treatment for that injury, nor is there any evidence a claim was filed for the injury prior to this matter, which involves claims filed more than ten years later. Further, Claimant's testimony indicates he was aware of symptoms which he related to that alleged injury when it occurred more than ten years ago. Accordingly, I find insufficient evidence establishing the 1991 or 1992 cleating accident caused an injury which is responsible for ongoing symptoms or is otherwise compensable.

On the other hand, it appears that Claimant argues the August 1, 2002 ladder incident in which his leg would not work caused his present back pain or otherwise exacerbated an underlying, pre-existing back condition related to his 1991 or 1992 cleating incident. Claimant's testimony that he experienced back pain related to cleating a submarine or to climbing and descending ladders during the course of his employment is plausible, which warrants invocation of the Section 20(a) presumption. However, Dr. Saris found no evidence

of injury and concluded Claimant's symptoms were entirely the result of age-related degenerative changes unrelated to any occupational injury, which I find is sufficient to rebut the Section 20(a) presumption.

Weighing the entire record as a whole, I find insufficient evidence establishing what, if anything, happened at work on August 1, 2002, to cause the back pain described by Claimant. Of the record physicians who rendered opinions regarding Claimant's back condition, Drs. Criscuolo and Saris offer opposing conclusions.

I find Dr. Saris's medical opinion that Claimant suffers from non-occupational degenerative changes which do not preclude his return to work is more persuasive, well-reasoned and supported by normal objective findings reported by both Drs. Saris and Criscuolo. I find Dr. Criscuolo's opinion that Claimant suffers from lumbalgia related to a work-related injury is undermined by his failure to describe the work-related event which occurred on August 1, 2002, or otherwise explain how the alleged injury was responsible for ongoing back pain. His opinion is further obscured by his later opinion that "much" of Claimant's significant symptoms were related to his abdominal aortic aneurysm, which "clearly take precedence" regarding work limitations and future medical interventions and treatments. Moreover, his opinion is attenuated by his negative findings upon physical examination and the absence of any records of follow-up treatment anticipated by Dr. Criscuolo on December 3, 2002.

I find Claimant's testimony that he experienced no pain or numbness upon the occurrence of the alleged August 1, 2002 incident, coupled with his statement that he experienced symptoms related to his aneurysm, fails to establish an occupational injury occurred and caused any disability on August 1, 2002. Further, I find his argument in brief that his back condition "would not be so severe as to drive him from work" fails to establish any residual disability related to his back condition. Arguably, it appears that, while Claimant disagrees with Dr. Saris over the occupational nature of his injury, he agrees with Dr. Saris that he is not disabled from returning to work by his back condition.

Further, I find references to back pain noted by Dr. Lentz, who indicated Claimant reported his pain was "primarily due to his back;" Dr. Crisafi, who did not diagnose any condition or provide any reason why Claimant was disabled from working on

August 7, 2002; Dr. Christian, who reported Claimant suffered from back pain without further explanation; and Dr. Alessi, who reported back pain without explanation in his review of systems, fail to establish what caused Claimant's condition or whether Claimant suffered any disability related to the condition.

Insofar as Claimant contends his August 1, 2002 injury exacerbated an underlying back condition, I find his argument is unpersuasive. The record fails to establish Claimant suffered an ongoing back condition prior to August 1, 2002. Claimant's testimony that he experienced back pain ever since the 1991 or 1992 injury is inconsistent with his report to Dr. Criscuolo that he was "well until August 1, 2002, when he suffered a work-related injury." Otherwise, there is insufficient medical evidence establishing Claimant treated for ongoing complaints of back pain prior to August 1, 2002. Consequently, in the absence of factual support, I find Claimant's contention that he sustained an August 1, 2002 injury which exacerbated an underlying and pre-existing back condition is without merit.

In consideration of the foregoing, I find Claimant failed to establish a compensable back injury which caused any disability. His claim for benefits related to his back condition is hereby **DENIED.**

C. Nature and Extent of Disability

Having found that Claimant suffers from a compensable injury, the burden of proving the nature and extent of his disability rests with the Claimant. Trask v. Lockheed Shipbuilding Construction Co., 17 BRBS 56, 59 (1980).

Disability is generally addressed in terms of its nature (permanent or temporary) and its extent (total or partial). The permanency of any disability is a medical rather than an economic concept.

Disability is defined under the Act as an "incapacity to earn the wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10). Therefore, for Claimant to receive a disability award, an economic loss coupled with a physical and/or psychological impairment must be shown. Sproull v. Stevedoring Servs. of America, 25 BRBS 100, 110 (1991). Thus, disability requires a causal connection between a worker's physical injury and his inability to obtain work. Under this standard, a claimant may be found to have either suffered no loss, a total loss or a

partial loss of wage earning capacity.

Permanent disability is a disability that has continued for a lengthy period of time and appears to be of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. Watson v. Gulf Stevedore Corp., 400 F.2d 649, pet. for reh'g denied sub nom. Young & Co. v. Shea, 404 F.2d 1059 (5th Cir. 1968)(per curiam), cert. denied, 394 U.S. 876 (1969); SGS Control Services v. Director, OWCP, 86 F.3d 438, 444 (5th Cir. 1996). A claimant's disability is permanent in nature if he has any residual disability after reaching maximum medical improvement. Trask, supra, at 60. Any disability suffered by Claimant before reaching maximum medical improvement is considered temporary in nature. Berkstresser v. Washington Metropolitan Area Transit Authority, 16 BRBS 231 (1984); SGS Control Services v. Director, OWCP, supra, at 443.

The question of extent of disability is an economic as well as a medical concept. Quick v. Martin, 397 F.2d 644 (D.C. Cir 1968); Eastern S.S. Lines v. Monahan, 110 F.2d 840 (1st Cir. 1940); Rinaldi v. General Dynamics Corporation, 25 BRBS 128, 131 (1991).

To establish a **prima facie** case of total disability, the claimant must show that he is unable to return to his regular or usual employment due to his work-related injury. Elliott v. C & P Telephone Co., 16 BRBS 89 (1984); Harrison v. Todd Pacific Shipyards Corp., 21 BRBS 339 (1988); Louisiana Insurance Guaranty Association v. Abbott, 40 F.3d 122, 125 (5th Cir. 1994).

Claimant's present medical restrictions must be compared with the specific requirements of his usual or former employment to determine whether the claim is for temporary total or permanent total disability. Curit v. Bath Iron Works Corp., 22 BRBS 100 (1988). Once Claimant is capable of performing his usual employment, he suffers no loss of wage earning capacity and is no longer disabled under the Act.

D. Maximum Medical Improvement (MMI)

The traditional method for determining whether an injury is permanent or temporary is the date of maximum medical improvement. See Turney v. Bethlehem Steel Corp., 17 BRBS 232, 235, n. 5 (1985); Trask v. Lockheed Shipbuilding Construction Co., supra; Stevens v. Lockheed Shipbuilding Company, 22 BRBS 155, 157 (1989). The date of maximum medical improvement is a

question of fact based upon the medical evidence of record. Ballesteros v. Willamette Western Corp., 20 BRBS 184, 186 (1988); Williams v. General Dynamics Corp., 10 BRBS 915 (1979).

An employee reaches maximum medical improvement when his condition becomes stabilized. Cherry v. Newport News Shipbuilding & Dry Dock Co., 8 BRBS 857 (1978); Thompson v. Quinton Enterprises, Limited, 14 BRBS 395, 401 (1981). If a physician does not specify the date of maximum medical improvement, however, a judge may use the date the physician rated the extent of the injured worker's permanent impairment. See Jones v. Genco, Inc., 21 BRBS 12, 15 (1988).

In the present matter, nature and extent of disability and maximum medical improvement will be treated concurrently for purposes of explication.

Claimant credibly testified he may no longer perform physical activities due to his pulmonary condition, which causes, among other symptoms, shortness of breath on physical exertion. Claimant's testimony is supported by the medical records establishing lung and pulmonary conditions with a loss of diffusion capacity. Consequently, in consideration of Claimant's testimony, medical records and the physical requirements of his carpentry job, including lifting, cutting, climbing ladders, and walking, I find Claimant established a **prima facie** case of total disability due to his compensable pulmonary and lung conditions.

Although it is unclear to what extent Claimant's asbestosis contributes to his pulmonary and lung conditions, Drs. Daum and Teiger generally agree Claimant's overall permanent impairment rating due to the combination of his pulmonary and lung conditions, including COPD, is 40% to 50% of the whole man in reliance upon Claimant's pulmonary function test results. Dr. Daum offered her opinion on August 29, 2003, while Dr. Teiger rendered his opinion on May 2, 2003.

Accordingly, I find Claimant reached maximum medical improvement from his pulmonary and lung conditions on May 2, 2003, based on Dr. Teiger's May 2, 2003 assignment of a 40% to 50% permanent impairment rating, which Dr. Teiger considered to be a Grade III permanent impairment under AMA criteria and which was generally affirmed by Dr. Daum's August 29, 2003 opinion. All periods prior to May 2, 2003, are considered temporary under the Act. Employer has provided no evidence of suitable alternative employment.

March 9, 2002 through April 30, 2002

Claimant argues he is entitled to compensation benefits since "March 2002." A review of the record establishes Claimant was admitted to the Westerly Hospital for treatment of his pulmonary condition and symptoms of increased shortness of breath on March 9, 2002. Although there are insufficient medical records establishing the length of time following Claimant's March 9, 2002 admission to the hospital until his return to work, Claimant's uncontroverted testimony that he returned to work on May 1, 2002 establishes his disability status from March 9, 2002 through April 30, 2002 as temporary total. Accordingly, since he was hospitalized for conditions found to be compensable, Claimant is entitled to disability compensation benefits from March 9, 2002 through April 30, 2002, based on his average weekly wage of $936.75.

May 1, 2002 through August 1, 2002

Although there is some indication that Claimant suffered from pulmonary maladies, as evidenced by his pulmonary function test results in March 2002 and July 2002, there is insufficient evidence establishing Claimant's condition precluded his return to work from May 1, 2002 through August 1, 2002. Claimant's uncontroverted and credible testimony that he worked "three months to the day" from May 1, 2002 until August 1, 2002, does not establish that his return to work prior to August 1, 2002, was only through the result of extraordinary effort or unusual hardship. Accordingly, I find Claimant was not disabled under the Act from May 1, 2002 through August 1, 2002, when he became disabled as a result of a non-occupational condition.

August 1, 2002 through November 30, 2002

The record establishes Claimant's disability on August 1, 2002, was related to a non-occupational back condition involving a non-occupational aortic aneurysm requiring surgery. Accordingly, I find Claimant failed to establish entitlement to compensation benefits from August 1, 2002 through November 30, 2002.

December 1, 2002 through May 1, 2003

On December 1, 2002, Claimant retired. Employer contends Claimant never returned to work after August 1, 2002 due to his non-occupational disability. Accordingly, Employer appears to

contend Claimant voluntarily retired for reasons unrelated to his occupational disability.

"Retirement" is defined as a situation wherein a claimant has voluntarily withdrawn from the workforce with no realistic expectation of return. 20 C.F.R. § 702.601(c). Under the Act as amended in 1984, when an employee voluntarily retires and his occupational disease becomes manifest **subsequent** to his retirement, his recovery is limited to an award for permanent partial disability based on the extent of medical impairment under AMA guidelines and is not based on economic factors. See 33 U.S.C. §§ 902(10), 908(c)(23), 910(d)(2); Hansen v. Container Stevedoring Co., 31 BRBS 155 (1997); Adams v. Newport News Shipbuilding & Dry Dock Co., 22 BRBS 78 (1989); McLeod v. Bethlehem Steel Corp., 20 BRBS 234 (1988).

A claimant is a voluntary retiree if he withdraws from the workforce for reasons other than the condition which is the subject of the claim. Hansen, supra at 157; Ponder v. Peter Kiewit Sons' Co., 24 BRBS 46 (1990). A claimant may be considered a voluntary retiree and receive benefits under Section 8(c)(23) even if a medical condition or other factors provided the impetus for his retirement as long as the occupational disease for which benefits are sought did not cause claimant's withdrawal from the workforce. Wayland v. Moore Dry Dock, 21 BRBS 177 (1988).

On the other hand, when a claimant's retirement is due, **at least in part**, to his occupational disease, the claimant is not a voluntary retiree and the post-injury provisions at Sections 2(10), 8(c)(23) and 10(d)(2) do not apply. Hansen, supra at 157; Pryor v. James McHugh Const. Co., 18 BRBS 273 (1986); McDonald v. Bethlehem Steel Corp., 18 BRBS 181 (1986). In such cases, where a claimant establishes he is unable to perform his prior job due in part to an occupational disease, he has established a **prima facie** case of disability. Under these circumstances, a claimant is entitled to an award based on his loss of wage-earning capacity and may therefore be entitled to permanent total disability compensation pursuant to Section 8(a) of the Act. 33 U.S.C. § 908(a). See generally Hansen, supra at 157; Smith v. Ingalls Shipbuilding Div./Litton Systems Inc., 22 BRBS 46 (1989); Truitt v. Newport News Shipbuilding & Dry Dock Co., 20 BRBS 79 (1987).

In the present matter, Claimant credibly stated his disability from returning to work was related to a combination of maladies, including his non-occupational back condition as

well as his compensable pulmonary and lung conditions causing shortness of breath upon physical exertion. His testimony is supported by records indicating the manifestation of occupationally-related pulmonary and lung conditions **prior to** his retirement, including his 1997 employment records indicating complaints of shortness of breath, his March 2002 hospital records indicating his breathing worsened prior to admission for medical treatment, and his pulmonary function test results in March 2002 and July 2002 indicating a problematic pulmonary condition, as discussed more thoroughly above.

Accordingly, I find Claimant's retirement was involuntary insofar as it was due, at least in part, to his compensable pulmonary and lung conditions which were manifest prior to his retirement. Therefore, Claimant's disability status became temporary total on December 1, 2002. Accordingly, Claimant is entitled to disability compensation benefits based on his average weekly wage of $936.75.[20]

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[20] It is noted that Claimant testified he receives Social Security disability benefits. Social Security disability benefits are offset by any recovery a claimant receives under the Act. Thus, a claimant receiving benefits under the Act will have his Social Security disability benefits reduced accordingly. 42 U.S.C.A. § 424, et seq.; Ladner v. Secretary of Health, Education and Welfare, 304 F. Supp. 474 (S.D. Miss. 1969)(when a claimant received a lump-sum payment for permanent partial disability compensation benefits under the Act, the Court affirmed a determination that the claimant's Social Security disability insurance benefits were subject to offset deductions under section 224 of the Social Security Act, 42 U.S.C. § 424a).

The record does not establish to what extent, if any, Claimant may be receiving retirement benefits. However, it is noted that the Board has held that an employer is not entitled to a credit under section 3(e) of the Act for the payment of retirement benefits, which are not compensation benefits. Wilson v. Norfolk & Western Railway Co., 32 BRBS 57, 63 (1998). The Board has also held that, when a totally disabled claimant retires due to eligibility for an age and length of service retirement pension, the award of total disability carries over into retirement absent employer's showing of the availability of suitable alternate employment. Hoffman v. Newport News Shipbuilding and Dry Dock Company, 35 BRBS 148, 151 n. 2 (2001) (citing Harmon v. Sea-Land Service, Inc., 31 BRBS 45 (1997)).

May 2, 2003 through Present and Continuing

On May 2, 2003, Claimant's disability status became permanent total when he reached maximum medical improvement. Insofar as Employer presented no evidence of suitable alternative employment, I find Claimant has established entitlement to disability compensation benefits for his permanent total disability status through present and continuing, based on his average weekly wage of $936.75.

E. Entitlement to Medical Care and Benefits

Section 7(a) of the Act provides that:

> The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.

33 U.S.C. § 907(a).

The Employer is liable for all medical expenses which are the natural and unavoidable result of the work injury. For medical expenses to be assessed against the Employer, the expense must be both reasonable and necessary. Pernell v. Capitol Hill Masonry, 11 BRBS 532, 539 (1979). Medical care must also be appropriate for the injury. 20 C.F.R. § 702.402.

A claimant has established a **prima facie** case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work-related condition. Turner v. Chesapeake & Potomac Tel. Co., 16 BRBS 255, 257-258 (1984).

Section 7 does not require that an injury be economically disabling for claimant to be entitled to medical benefits, but only that the injury be work-related and the medical treatment be appropriate for the injury. Ballesteros v. Willamette Western Corp., 20 BRBS 184, 187.

Entitlement to medical benefits is never time-barred where a disability is related to a compensable injury. Weber v. Seattle Crescent Container Corp., 19 BRBS 146 (1980); Wendler v. American National Red Cross, 23 BRBS 408, 414 (1990).

In consideration of the foregoing, Claimant established entitlement to medical benefits for his compensable pulmonary and lung conditions. Employer is liable for all medical expenses which are the natural and unavoidable result of the pulmonary and lung conditions.

However, Claimant's failure to establish his back condition is a compensable injury under the Act precludes his entitlement to medical benefits for his back condition. Employer shall not be liable for medical treatments related to Claimant's back condition. Claimant's alleged hand condition, as noted above, was not at issue in this matter, and Employer's potential liability may be determined by the District Director on remand.

V. INTEREST

Although not specifically authorized in the Act, it has been an accepted practice that interest at the rate of six per cent per annum is assessed on all past due compensation payments. Avallone v. Todd Shipyards Corp., 10 BRBS 724 (1974). The Benefits Review Board and the Federal Courts have previously upheld interest awards on past due benefits to insure that the employee receives the full amount of compensation due. Watkins v. Newport News Shipbuilding & Dry Dock Co., aff'd in pertinent part and rev'd on other grounds, sub nom. Newport News v. Director, OWCP, 594 F.2d 986 (4th Cir. 1979). The Board concluded that inflationary trends in our economy have rendered a fixed six per cent rate no longer appropriate to further the purpose of making Claimant whole, and held that ". . . the fixed per cent rate should be replaced by the rate employed by the United States District Courts under 28 U.S.C. § 1961 (1982). This rate is periodically changed to reflect the yield on United States Treasury Bills . . . ." Grant v. Portland Stevedoring Company, et al., 16 BRBS 267 (1984). This order incorporates by reference this statute and provides for its specific administrative application by the District Director. See Grant v. Portland Stevedoring Company, et al., 17 BRBS 20 (1985). The appropriate rate shall be determined as of the filing date of this Decision and Order with the District Director.

VI. COST OF LIVING INCREASES

Section 10(f), as amended in 1972, provides that in all post-Amendment injuries where the injury resulted in permanent total disability or death, the compensation shall be adjusted annually to reflect the rise in the national average weekly wage. 33 U.S.C. § 910(f). Accordingly, upon reaching a state

of permanent and total disability on May 2, 2003, Claimant is entitled to annual cost of living increases, which rate is adjusted commencing October 1 of every year for the applicable period of permanent total disability, and shall commence October 1, 2003.[21] This increase shall be the lesser of the percentage that the national average weekly wage has increased from the preceding year or five percent, and shall be computed by the District Director.

VII. ATTORNEY'S FEES

No award of attorney's fees for services to the Claimant is made herein since Employer have not responded to Counsel for Claimant's application for attorney's fees. Employer is hereby allowed thirty (30) days from the date of service of this decision by the District Director to submit its objections to Counsel for Claimant's application for attorney's fees.

VIII. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law, and upon the entire record, I enter the following Order:

1. Employer shall pay Claimant compensation for temporary total disability from March 9, 2002 to April 30, 2002, based on Claimant's average weekly wage of $936.75, in accordance with the provisions of Section 8(b) of the Act. 33 U.S.C. § 908(b).

2. Employer shall pay Claimant compensation for temporary total disability from December 1, 2002 through May 1, 2003, based on Claimant's average weekly wage of $936.75, in accordance with the provisions of Section 8(b) of the Act. 33 U.S.C. § 908(b).

3. Employer shall pay Claimant compensation for permanent total disability from May 2, 2003, to present and continuing thereafter based on Claimant's average weekly wage of $936.75, in accordance with the provisions of Section 8(a) of the Act.

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[21] See Trice v. Virginia International Terminals, Inc., 30 BRBS 165, 168 (1996)(It is well established that claimants are entitled to Section 10(f) cost of living adjustments to compensation only during periods of permanent total disability, not temporary total disability); Lozada v. Director, OWCP, 903 F.2d 168, 23 BRBS 78 (CRT) (2d Cir. 1990) (Section 10(f) entitles claimants to cost of living adjustments only after total disability becomes permanent).

33 U.S.C. § 908(a).

4. Employer shall pay to Claimant the annual compensation benefits increase pursuant to Section 10(f) of the Act effective October 1, 2003, for the applicable period of permanent total disability.

5. Employer shall pay all reasonable, appropriate and necessary medical expenses arising from Claimant's pulmonary and lung conditions pursuant to the provisions of Section 7 of the Act.

6. Employer shall pay interest on any sums determined to be due and owing at the rate provided by 28 U.S.C. § 1961 (1982); Grant v. Portland Stevedoring Co., et al., 16 BRBS 267 (1984).

7. Employer shall have thirty (30) days from the date of service of this decision by the District Director to file its objections to Counsel for Claimant's fee petition.

ORDERED this 28th day of May, 2004, at Metairie, Louisiana.

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LEE J. ROMERO, JR.
Administrative Law Judge